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ABSTRACT

This handbook consists of 24 papers addressing various aspects on health care and health care systems and services for foreign students from the Asia Pacific Region. The papers are: "Providing Health Care for International Students" (Donald F. B. Char); "Major Health Care Systems in Asia and the Pacific: Mainland China, Taiwan, Hong Kong" (Julia J. Tsuei); "The Health Care System of Korea" (Chai Bin Park); "Characteristics of Burma's Medical/Health Care System" (Burmese students in Hawaii); "Tips on Health Care for Indochinese Students" (An T. Nguyen); "Health Care in the Cultural System of Indonesia" (Agus Suwandono); "Malaysian Health and Cultural Beliefs" (Farida H. Che Din); "The Student from the Phillipines" (Divina A. R. Telan-Robillard); "Health and Culture in Thailand" (Chamnan Prasertchoung); "Health Care for Micronesia Students" (Donald H. Rubinstein); "The Health Care System of Papua New Guinea" (Georgeda Buchbinder); "The American Health Care System: Its Organization and Operation" (Robert E. Mytinger); "Preventive Assistance and Health Care" (Nancy Stockhert); "Counseling Asian and Pacific Island Students" (Nancy Stockhert; June Naughton); "Nutrition" (Jan Pachelbel); "Sexuality and Sexual Harassment" (Nancy Stockhert); "Academic Problems" (June Naughton); and, "Crisis Information" (June Naughton). Appendices include a checklist for foreign student advisers handling death-related events for international students/scholars, 46 chapter references, and an evaluation form requesting comments and suggestions about the handbook. (LPT)

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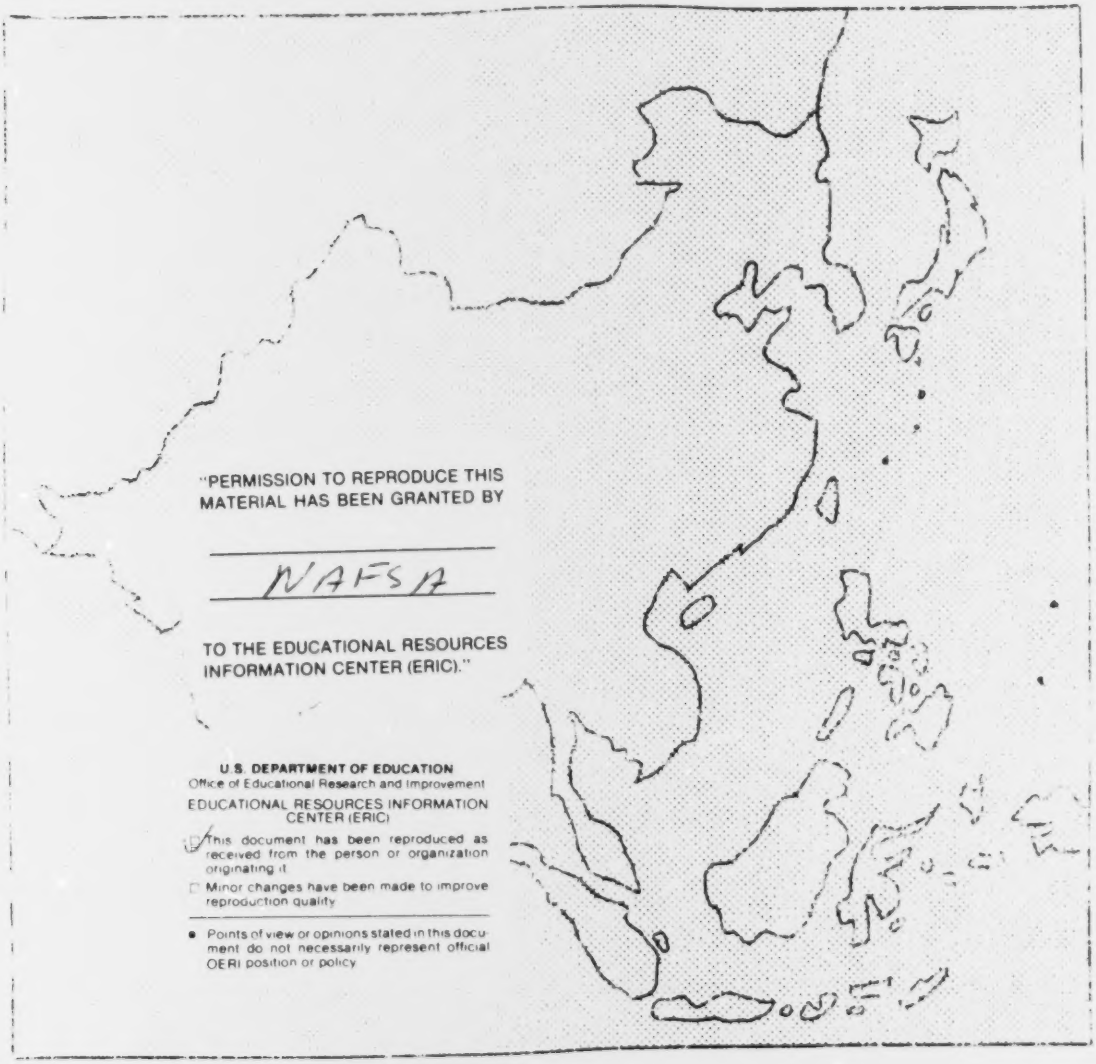
HEALTH CARE

FOR THE INTERNATIONAL STUDENT:



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ASIA AND THE PACIFIC

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HEALTH CARE FOR THE INTERNATIONAL STUDENT:

ASIA AND THE PACIFIC

Edited by
June C. Naughton
Stephen G. Karel
Nancy A. Stockert

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PREFACE

In 1985, NAFSA-Hawaii held its first workshop on Health Concerns for the Asian and the Pacific student under the direction of Stephen Karel. That stimulated a series of discussions which led to a suggestion that a handbook would assist advisers to give more sensitive help to the many Asian and Pacific students with problems related to their health and well being. Information could be drawn from the many resources found at the University of Hawaii. Stephen Karel, the Health Officer from the East-West Center, coordinated the section on Health Care Systems in Asia and the Pacific, Nancy Stockert, the Administrative Assistant at the Student Health Service (University of Hawaii) compiled the section on Preventive Health Care, and June C. Naughton, Foreign Student Adviser (University of Hawaii) completed the section on Crisis Information.

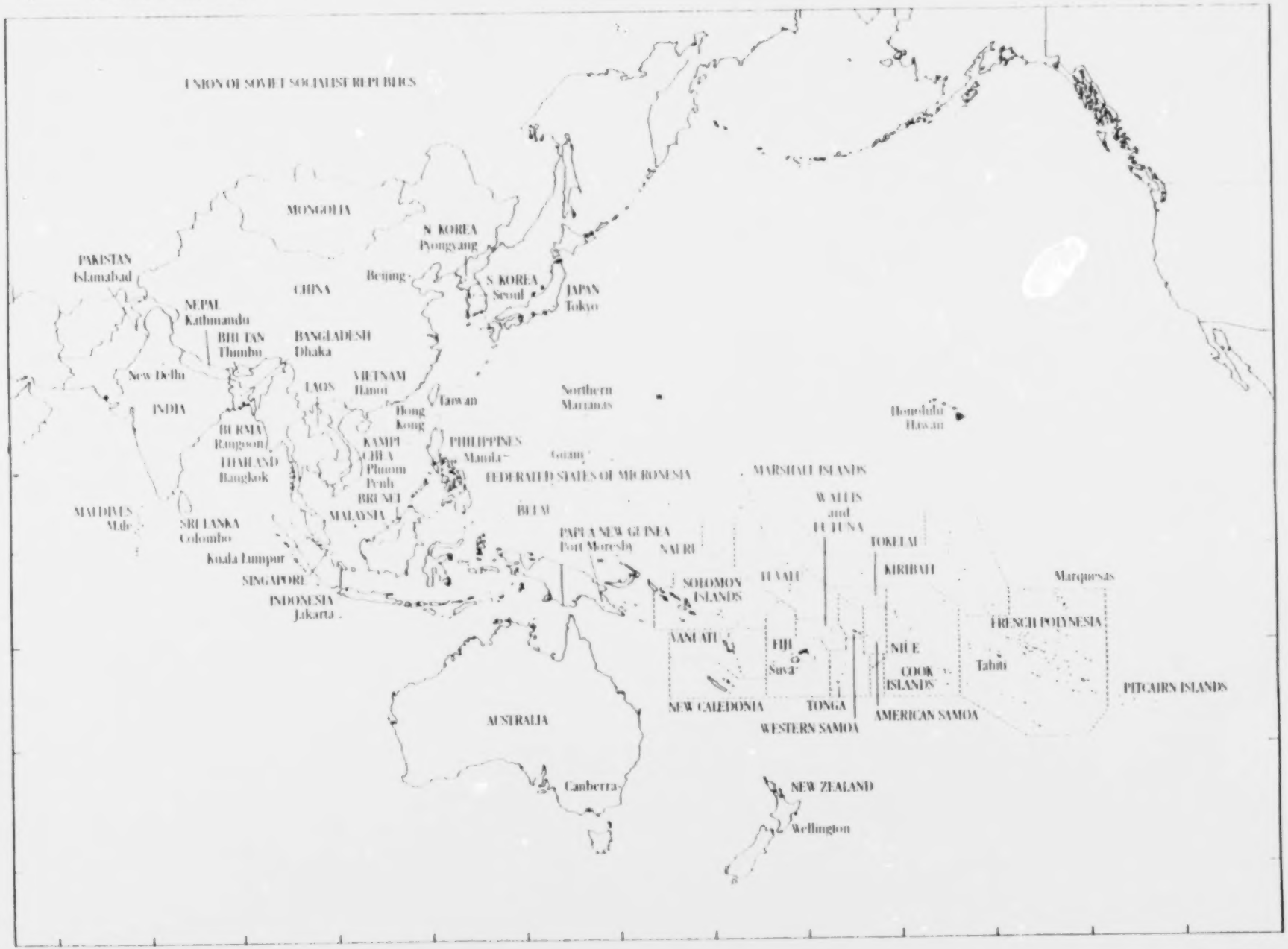
HEALTH CARE FOR THE INTERNATIONAL STUDENT: Asia and the Pacific is the result of six months of collaborative effort and is a project of the Asian and Pacific Area Interest Committee (APSIA). It is funded by a Professional Development Grant from the Field Service of the National Association for Foreign Student Affairs (NAFSA). NAFSA's Field Service is supported by the Student Support Services Division of the U.S. Information Agency.

The editors gratefully acknowledge the contributions of the many authors who have made this handbook possible especially those from the UH School of Public Health. We also want to thank those students who have shared information about their culture and adjustment processes in the United States. We cannot forget Lisa Hancock-Leung, Jane Jones, Ely Meyerson, Norman Meller, and Sharron Aana for the completion of this handbook and the cooperation tendered by the East-West Center.

In writing this handbook it became necessary to make use of numerous generalizations. It is important to remind readers that stereotyping of individuals or groups of people from these generalizations should be avoided. As a matter of convenience, the masculine pronoun is frequently used but, as appropriate, should be construed to mean both genders. This handbook is intended to be a working document and is not yet complete with some major areas of Asia and the Pacific still unavailable. All comments that may assist in clarifying or expanding the contents of this handbook are most welcome.

JUNE NAUGHTON
University of Hawaii
May, 1986

The Asia Pacific Region



Source: Asia-Pacific Report: Trends, Issues, Challenges,

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I.

Introduction

PROVIDING HEALTH CARE FOR INTERNATIONAL STUDENTS

Donald F.B. Char, M.D.
Director, Student Health Service
Professor of Pediatrics
University of Hawaii

When I first entered the field of college medicine over 20 years ago, I was confident in my ability to solve most medical problems. Having spent almost 20 years preparing for this medical profession, following extensive training in universities, hospitals and clinics, and having participated in research as well as medical teaching, it seemed inevitable that I should feel this way.

However, moving out of the ivory towers of university teaching centers, I was due for a real surprise! Patients did not seem to respond and behave as I was led to believe in my schooling. They appeared to misunderstand my instructions, often failing to conform or comply with them; they often questioned me and appeared to doubt my knowledge; even when they appeared to accept my advice, they obviously modified it according to their wishes and desires.

It was then that I began to realize that my medical education, involving largely scientific biomedical concepts, focused too largely on disease itself and was largely bonded to Western models of humanity and human behaviors. Even though instructed to "look at and treat the whole person" by most of my teachers, it was obvious by their examples that most of them were incapable of applying these comprehensive principles in actions. Finding my role of providing care greatly shaped and molded by my scientific knowledge and technical skills, I began to realize that I had to develop a personal style of caring. Even though warned against imposing a personal sense of values and ethics on my patients, I nevertheless came to realize that these basic principles needed to be somehow incorporated and reflected in my caring. My patients needed to know me as a good, virtuous, compassionate person, and all my knowledge and information about medicine was for naught if they could not trust me.

Thus, my patients added to my education toward becoming a better physician. International students, coming from such welter of cultures and societies, greatly facilitated this process. In responding to their appeals for help with their health problems, I began to realize that I also shared many of their questions and perplexities regarding health and medical care from a trans-cultural perspective. I began to appreciate some of the shortcomings of our intense adherence to science and technology; and realized that fundamental

human values are in caring for others. Although born and schooled in Western ways, I began also to realize that I had to accept and deal with alternatives to Western thoughts of human behavior.

It soon became apparent to me that my experiences were beginning to fall into a distinct pattern, and from my readings I found out that I was venturing into the field of medical anthropology. Thus, I began to spend more time in libraries, reading and reflecting on the accumulated insights and knowledge gained from researchers in this field. From this medical anthropologic storehouse of knowledge I found myself greatly reassured that I was on the correct track as a clinician.

I would like to share some of these medical anthropologic insights in cross-cultural health care with you. Using these concepts I wish to discuss some major pitfalls that one must learn to assist international students in health care matters.

PITFALL 1 The need for an expanded view of the normal health care system.

In our highly developed, post-industrialized societies of the world, we have been conditioned to deal with highly specialized occupations and roles. Nowhere is this more evident than in the health care system of the United States where the average American has learned to accept narrowly focused specialists in medical care, and, in general, can find an expert for every field of caring. Unfortunately, there has been an accompanying loss of normal social caring and supportive networks in our world because of this need to consult experts for solutions to every problem.

Dr. Arthur Kleinman, a psychiatrist-anthropologist, who lived and studied the Chinese living on Taiwan, investigated their use of the health care system. He characterizes all health care systems of the world in Figure 1.

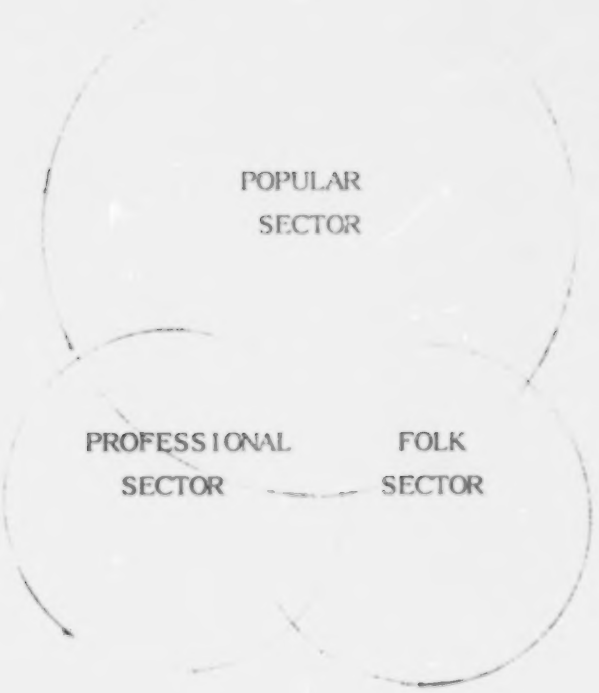
Note that these three sectors all overlap each other in most societies, though particularly in the West, the professional and folk sectors need not do so. Physicians trained in biomedicine dominate the professional sector in the Western communities, but in Asia, this may be East Asian or Ayurvedic medicine. Through the folk sector we see where spiritual concepts may contribute significantly to healing activities.

This expanded vision of the normal health care system demonstrates that every individual possesses many more options and choices to make in confronting a health care problem and is not limited to the professional provider, as we commonly assume. In fact, sociologic research shows that less than 10% of all illnesses in England and the United

FIGURE 1.

THE HEALTH CARE SYSTEM

(From: Patients & Healers in Context of Culture - Kleinman)



Popular Sector

Based on individual, family, social networks and community.
Health and illness defined and activities conducted:
Beliefs, Roles, Relationships, Interaction Settings,
Institutions, Choices and Decisions.
Inadequately studied and poorly understood.
Between 70-90% of illnesses managed exclusively in this sector.

Professional Sector

Made up of organized healing professions--for most, modern scientific biomedicine.
In Asia, East Asian (Chinese) or Ayurvedic medicine.
Allopathic medicine dominates in United States.

Folk Sector

Sacred and secular parts, although often blurred in practice.
Shamanism, herbalism, manipulative treatments, exercise often blend into popular sector.

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States involve the professional sector; the vast majority being cared for by self or others in the social networks. It is important to conceptualize the processes of help seeking behavior in health matters. An individual must first recognize a problem, the symptom. If it is sufficiently disturbing, self care remedies can be applied. Should this problem persist, friends, family, and significant acquaintances may be consulted and the problem may be resolved. Only if these measures fail, and with the passage of time if the problem persists or worsens, this individual becomes a patient and enters into the professional domain.

One can see how this process works in Hong Kong in Table 1 by comparing the preferences of the natives when it comes to choosing between the Western physicians and the traditional

Table 1: Personal Attitudes Toward Western vs. Chinese Medicine

	Western Better	Chinese Better	About the Same
1. Tuberculosis	91.2%	1.4%	7.4%
2. Fever	90.5	5.7	3.8
3. Heart Diseases	84.9	0.9	14.2
4. Stomach-ache	84.3	3.4	12.3
5. Mental illness	84.0	0.4	15.5
6. Skin diseases	83.6	6.6	10.4
7. Diarrhea	78.3	13.4	8.3
8. Whooping cough	76.9	14.0	9.1
9. Dysmenorrhea	65.0	17.5	17.4
10. Anemia	55.0	29.1	16.0
11. Measles	47.9	47.0	9.1
12. Rheumatism	24.2	54.1	21.7
13. Sprains and fractures	8.2	86.5	5.3

Source: Culture & Healing in Asian Societies. R.P.L. Lee

Chinese medical practitioners. Although you can see that Western medicine is considered better for the majority of illnesses, note that there are many adherents to Chinese medicine throughout. For certain conditions, such as rheumatism and fractures, many natives believe that traditional practitioners are superior.

That measles belong to the group where Chinese medicine is preferred over Western medicine appears to be shocking. Physicians will say that there is no cure for measles. I found out, while living and working on the campus of Chinese University of Hong Kong, that the natives claimed that Chinese herbal medicines were superior to Western medicines because they would accelerate the spread of the rash over the entire body. As most health providers know, once the rash spreads widely, the fever dissipates and the patient begins to improve. Whether this claim for herbs is justified or not

I do not know. I know that complications and deaths from measles still occur in employing these traditional herbal medicines.

PITFALL 2. A tendency to focus too narrowly on disease concepts to the ultimate neglect of the person having the illness.

As discussed at the onset, Western physicians may overemphasize the measurements and evaluation of the disturbances brought about by the malady. Applying scientific, biomedical technology, testing and examinations are performed, often leading the patient to feel that he or she is excluded from this process. Ultimately, such patients begin to feel that they are merely an organ or a tissue to be poked, probed and sampled and even attempts to communicate with compassion and feeling may become strained. Many patients complain of this alienating experience, but this problem can be magnified greatly among foreign students, who commonly lack adequate communication skills, and too often are conditioned to accept the unquestioned authority of the physician. Feeling helpless to question or stop the process, foreign students may be forced to endure less than desirable medical care.

PITFALL 3. A splitting apart of the mental-emotional from the physical-organic concepts of health.

Most Western-educated clinicians are trained to search for etiologic explanations, designing specific treatment and management strategies to care for these explicit diagnoses. Mental health practices of the West, ostensibly based upon scientific, secular, and value-free concepts of humanity, almost invariably are wedded to ideas prizing individualism and reductionistic analyses. Most other cultures and societies treasure group and family needs, with harmony as its highest value.

Mental health practices are based almost exclusively upon studies and research of human beings living in the West. It is therefore important to realize that many of our foreign students may not be well served by our attempts to manage their problems employing our largely Western or American notions of personality and behavior. Psychotherapy, when applied, must be wisely and prudently employed.

PITFALL 4. The great tendency to somatize disorders in international students.

The last major pitfall in health care involves the rather common occurrence of somatization disorders in foreign students.

Table 2: Symptoms of Somatization Disorder

Sickly: Patient believes that he or she has been sickly for a good part of his or her life.

Conversion or pseudoneurologic symptoms: Dysphagia, loss of voice, deafness, double vision, blurred vision, blindness, fainting or loss of consciousness, memory loss, seizures or convulsions, difficulty walking, paralysis or muscle weakness, urinary retention or difficulty urinating.

Gastrointestinal symptoms: Abdominal pain, nausea, vomiting spells, bloating, intolerance to a variety of foods, diarrhea.

Female reproductive symptoms: Excessively painful menstruation, menstrual irregularity, excessive bleeding, severe vomiting throughout pregnancy or causing hospitalization during pregnancy.

Psychosexual symptoms: Sexual indifference, lack of pleasure during intercourse, dyspareunia.

Pain: In back, joints, extremeties, genital area, or elsewhere, except headaches; dysuria.

Cardiopulmonary symptoms: Dyspnea, palpitations, chest pain, dizziness.

Source: Somatization Disorders in Primary Care
Monson and Smith, NEJM 308, 1464; 1983.

Table 2 reminds one of how the symptoms of somatization disorders can affect and involve every part of the body. In the course of my experiences, I have cared for foreign students with every one of these complaints.

In the beginning, I referred many of these patients to specialists. In the hands of many of these specialized physicians, it commonly resulted in exhaustive laboratory and other technical examinations, often compounding the problem and dysfunction and reinforcing the sick role.

Attempts to use the psychiatrist for these somatization disorders also was frustrating. These patients would become labeled with diagnosis such as conversion disorder, hypochondriasis or psychogenic pain disorder, and would have to be confronted with the notion that the problem was "all in the mind."

Dr. Kleinman, in commenting on these disorders, points out that our Western orientation leads us to assign dominance of mind over matter, creating the order in the term "psychosomatic." He points out that, in view of our lack of clinical insights and a dearth of success in managing these states, we need to reverse this order and should refer to them as somatopsychic disorders.

At a recent meeting of the American College of Gastroenterology, Dr. Peter Weigan, a psychiatrist, pointed out that the "the irritable bowel patient is not one that one would classify as psychologically disturbed." He believes that this disorder is learned. "We are finding that irritable bowel patients have a history of being rewarded for complaining about their physiologic problems--by their parents early in life and then by their circle of friends later. It is socially rewarding and attention getting to discuss problems, and in an individual who is somewhat socially deprived, feeling and discussing problems can be very reinforcing."

Unfortunately, psychotherapeutic treatment for these individuals afflicted with somatization disorders is most often lacking in success and frequently leads to alienation of these patients.

A case study of Muhammed illustrates this problem. Muhammed, a 23-year-old Bengali student, arrived on campus just as the civil war between Pakistan and Bagladesh was being fought.

He presented the physician with multiple abdominal complaints in the very first week of classes. Suspecting a diagnosis of a psychophysiologic disorder, he was treated symptomatically with medication by the physician. He came to the Student Health Service so regularly that he was soon seen by every one of the physicians on the staff. Attempts to refer him for psychiatric evaluation were initially refused, but upon the persistence of one physician, he finally did manage one visit, but refused to follow through.

American friends off-campus advised him to consult another physician in private practice. After an extended workup, including many laboratory examinations and x-rays, the diagnosis of "gastritis" was established and, again, medications prescribed. The symptoms persisted, so the private physician finally referred him to a surgeon in his clinic for consultation. Even though the surgeon initially agreed that surgery was not indicated, Muhammed continued to complain of the pain. The surgeon finally decided to operate to determine the source of the problem, and, at surgery, the diagnosis of "gastritis" was reconfirmed and medical treatment was reinstituted.

Muhammed graduated from our University, and I last saw him when he came to us for our assistance in arranging for an immigrant visa to Canada.

This story, although uncommon, shows how a foreign student may be dealt with in our technologically oriented and highly specialized medical care system in the West.

At present, it is my practice to retain full control over

these patients, and I work to win their confidence and establish good rapport. I still may refer these patients to specialized consultants. I generally communicate directly with these consultants and clearly define what I would like from this process. I usually request that they send their impressions back to me for my management whenever possible, but if they retain full control, I maintain frequent contact with them and the patient.

In this brief discussion, I have only mentioned some of the major pitfalls facing the foreign students using our Western medical care system to provide a sensitivity to the deeper issues and concepts underlying the problems of providing health care for international students. In caring for our foreign students, one needs to be ever mindful of the special needs of this group.

Let me end with a quotation from Dr. Sigmund Freud, the preeminent psychiatrist: "Now and then, occasions arise in which the physician is bound to take up the position of teacher and mentor, but it must be done with great caution, and the patient should be educated to liberate and to fulfill his own nature and not to resemble ourselves."

II.

Major Health Care Systems in Asia and the Pacific

MAJOR HEALTH CARE SYSTEMS IN ASIA AND THE PACIFIC: MAINLAND CHINA, TAIWAN, HONG KONG

by Julia J. Tsuei, M.D.

Chinese medicine was recorded as early as the beginning of history in China. In the prehistorical period, according to legend, the founder of Chinese medicine was Shen Nung, the Divine Husbandman, and it was he who had supposedly tasted hundreds of herbs and divided them into various categories of remedies for treatment of diseases during his life-time (2838 - 2698 B.C.). Thus, the writing of "The Herbal", considered to be the oldest Chinese medical treatise, was attributed to him. In "The Herbal", believed to have been written some 2,000 years later, 365 drugs were identified for their therapeutic effectiveness, and the usage has been followed up until today by physicians practicing Chinese traditional medicine.

From the beginning of Chinese medicine, administering herbs or pharmacological therapy composed a very large part of medical practice. Like other civilizations in other parts of the world, the development of medicine started with the belief that the cause of diseases is actually the curse of evil spirits. Therefore, the early medical men of China were priests or sorcerers. As more evidence proved that the herbal therapy is as good or even better than the ritual treatment for most of the diseases, Chinese medicine evolved from a medical-cum-ritual service into a distinct profession and practiced by specially trained persons or physicians. This evolution can be seen in the transformation of the Chinese character for doctor. The ancient character was written like this " ", the bottom half, " ", being the symbol for priest or sorcerer. Later, this portion of the character was changed to the symbol for wine " ", denoting that medicine was not the work of a priest, but rather that of physicians who administered elixirs to the sick.

In the beginning of recorded history, during the Chou Dynasty (1122 - 115 B.C.), there were four categories of doctors, namely, physicians, surgeons, dieticians and veterinarians. Some of the dietary standards and manuals established by the official dieticians of that time, handed down through the years, became the common belief of the Chinese communities of today. Examples are that some foods are considered as "cold", "hot", "yin" or "yang", and specific kinds of food are forbidden to be eaten in certain seasons or during certain illnesses, etc.

From the Chou Dynasty on, Chinese medicine was practiced under the general philosophy that the relationship of man and nature is that of the Microcosm living within the Macrocosm. A human being is looked upon as a small universe, and the

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anatomical structures and the physiological functions of the body react promptly to the outside environment - the large universe. When everything co-exists in perfect harmony, a person is in excellent health. Since the physiological process is in continual change and balance, as are the environmental conditions, this delicate change and balance between the small and the large universe are constantly being readjusted in every respect. Once the balance is disturbed, illness sets in. In other words, "good health" means the state of equilibrium within one's body and within one's surroundings. The way of maintaining and promoting health is to keep the balance of the body functions, the body and the mind, the person and his environment. When there is a disruption of the balance of the body function or body and mind either by trauma, bacterial viral infection, environmental changes or stress, traditional Chinese physicians use either the pharmacological approach -- herb medicine, or the physical approach -- acupuncture, moxibustion, cupping and bone setting to help to regain balance. For the extreme mental stress or illness, medical-cum-ritual treatment by the priests and other religious specialists were practiced in order to gain balance between the mind and the body. This theory of "balance" was well expressed by a set of symbols such as "ying" and "yang" representing two equal but opposite forces. The symbols of five elements namely "metal", "wood", "fire", "earth" and "air" are used to describe the interrelated balance among the organs and functions within the body as well as the balance with the surroundings.

The introduction of Western medicine into China started in the late 17th Century when the East India Company of England sent doctors from their ships to China. The first Chinese medical student, Wang Fong, was sent to Edinburgh, Scotland, in 1848 and received his medical degree in 1853. In 1866, the first Western medical school was established in Canton, China. In 1929, the Republic of China legalized the Western practice of medicine and adopted it as the official health care system. While the traditional Chinese medicine and some medical-cum-ritual treatments were still being practiced among the vast majority of the population, particularly in the rural areas, this new policy roused very serious cultural and intellectual controversies, because traditional Chinese medicine has been deeply embedded into the Chinese culture and is almost identified as a way of life. After years of debating, it was decided that the traditional medical system should be preserved in a modern context and the new Nationalist government offered license to the practitioners of both systems. From thereon, a dual system of medical practice became a pattern of health care system in China, Taiwan, Hong Kong, Singapore and all the Chinese communities throughout the world. An objective comparison of Chinese and Western approaches to medicine may be necessary in order to study the behavior of the masses living under this dual

system of health care.

The Western approach clearly divides health from disease and the health care system into preventive and acute care. The service providers also belong to two different groups: the public health worker and the medical doctors. The Chinese traditional approach considers health as a balanced state versus the unbalanced state of disease. The physician should treat the disease to maintain health. The Western approach looks into every aspect of a person with great detail, from a microscopic to macroscopic view of biology, embryology, histology and microbiology, studies the cellular level of chemistry and physics, then looks at the basic anatomy and physiology, and clinically classifies the care into internal medicine, surgery, pediatrics, obstetrics, and gynecology, psychiatry, etc. The Chinese approach looks into the environment first such as the weather, the hours of the day, the month of the year and looks at the body function in relation to all of these. Instead of the parts of the body, the Chinese doctor looks at the energy flow (biological activities) of the twelve anatomical physiological and psychological units of the body (the meridians and the pulse of the meridians), its balance within the body and in its surroundings. The causes of the diseases are divided into six external (environmental) insults and seven internal (emotional) insults. All diseases are represented by symptom groups or syndromes.

In the therapeutic aspect, the Western approach tends to change the environment. For example, if the weather is not ideal for the body, a shelter is built with temperature control; if the atmosphere and humidity are not comfortable, other controls are added; antibiotics are developed to counteract bacterial infections; sterile techniques are practiced as shelter from the bacterias; artificial limbs and organs are used to replace diseased body parts; synthetic hormones and vitamins are used for replacing body deficiencies. The Chinese approach may be passive toward, or may simply ignore, the idea of converting the environment. Its emphasis is from "within" to strengthen the enormous defensive and adaptive powers of one's body, so that the latter may accommodate physical or mental stress and keep the body and function balanced. It may work slowly or appear to be less effective; but if successful, the result usually is a balanced, comfortable body in a holistic sense, and its healing lay in fact that it embraced the patient's whole way of life. It began with everyday food, which formed a part of the medical system, acting as preventive dietetics. Then it considers regular sleep, sexual intercourse, physical exercise, and other activities as a comprehensive system of health practice. Based on these differences, it will be very interesting to find out how people make their choice when both systems are available at the same place.

Mainland China

When the People's Republic of China established the new regime in 1949, the government examined the health needs of the nation. There was a realization that traditional medical practices have been a great help to the people, and moreover, a large body of evidence suggested that many of the treatments did indeed work. After 1949, there was neither enough manpower nor money to introduce Western medicine. Thus it was decided in 1950, and has been policy ever since, to integrate Western practices with traditional Chinese practices, using whatever worked, discarding what did not. (Barefoot Doctor's Manual, 1977).

By the mid-1950's, Chinese medicine had become a required subject in all modern medical schools, and practising Western-styled physicians were pressured to enroll in spare-time courses in Chinese medicine. At one time, there were 2,000 doctors drawn from regular service for three years to do full-time study of traditional Chinese medicine. Enormous numbers of home prescriptions were collected and studied to prove their effectiveness, and dubious modern doctors were exhorted to use traditional remedies in their practices. However, despite the support of research centers and training of dual-system doctors, there were no major research breakthroughs in explaining the principles behind traditional therapy in modern western scientific terms. And in actual
medical practice, although Chinese medicine remained very popular, especially in the rural areas, it was generally alongside of, not integrated with, Western medicine. Furthermore, due to the influence of the Cultural Revolution and other political factors, the years of medical education in medical schools both in Western medicine and Chinese traditional medicine were shortened (3-4 years). For instance, the Chinese medicine in the hands of the crash-course-trained barefoot doctors or medical graduates make no reference to the basic principles of acupuncture but practiced it empirically. As a result, there were questions about the quality of medical care provided in both modern and traditional medicine.

After 1976, different medical schools began to reinstitute its reasonable curriculum years (6-8 years). The whole nation focused its attention to the the technical expertise for modernization with more emphasis on sophisticated medicine. In the major medical centers, only acupuncture clinics and some herbal medicine in the pharmacies remained as a regular fixture, and the main service provided tends to be the Western style. The same trends are practiced in large general hospitals of state and provincial levels. In district or township hospitals and clinics, especially in the rural areas, the Western type of medicine is scarce, but the supply of herbal medicine manufactured by the government

pharmaceutical factories is abundant, and more traditional practice is available on and assortment of remedies level rather than as a medical system. Living in this environment, the average Chinese acquired the knowledge of herbal treatment for common ailments such as headaches, indigestion, diarrhea, constipation, etc. Almost all households have a supply of herbs as home remedies. Friends and relatives will exchange treatments as they exchange cooking recipes. In addition, there are many foods believed to have specific therapeutic effectiveness, and there are many kinds of herbs taken as food for the sick as well as for healthy people. Many believe that certain herbs can cure the disease for one who is sick; and for one who is not, it can promote his health. In some severe acute illness, as syncope due to heat etc., there is always someone in the neighborhood who can perform first aid, cupping, acupressure, even acupuncture. Therefore, in general, when one is ill, Chinese will look into the medicine box at home for the answer, and only if it is not helping will the patient visit the clinics of hospitals.

Taiwan

In Taiwan, the Republic of China, the Western type of practice of medicine was adopted in 1929. There are five Western styled medical schools that provide a high physician/population ratio. In 1978, there were 10,939 Western trained physicians in service, (1,551 population/physician), and the Western trained physician rate is 6.4/10,000 population. However, the traditional Chinese medicine has been recognized by the government by continuing to license the practitioners who received proper training (usually under a tutorship for many years) and passed a strict two-part qualification examination. There were 1,546 traditional Chinese medical doctors registered in 1978, and the personnel/population ratio was 0.9/10,000. There is one private medical school, which has a Chinese Medicine Department, in which every medical student has to take one and a half academic years of Chinese medicine. This medical school has the only hospital in which Chinese traditional medicine is practiced. None of the government hospitals or private hospitals has Chinese medicine departments.

In Taiwan, practitioners who practice traditional Chinese medicine and acupuncture have their own clinics or herbal stores. Unless by special arrangement, they do not see patients in the hospitals. For the past ten years, there has been a genuine interest in acupuncture and Chinese herbs among the Western trained physicians. Some teaching hospitals and medical centers began to operate acupuncture clinics and herbal research became part of the medical school's new topics. However, in general practice, there are no referrals between the two systems.

When a person in Taiwan seeks medical service, because of the high physician and population ratio and the availability of private doctor's clinics, a Western trained physician is consulted first. People, in general, expect the Western doctor to produce clearly visible success as rapidly as possible. Rapid results are necessary for the doctor to maintain his "scientific image" and to keep patients from seeking relief from another doctor. The custom of changing doctors after a short time, if dissatisfied with his treatment, is widespread, and is historically documented for centuries. Thus, the Western trained doctors tend to use fast acting antibiotics, spasmolytics and analgesics in the form of injection. Under the present hospital law of Taiwan, the doctor's clinic is allowed to admit in-patients. Therefore, only the very ill or infectious cases will be sent to the hospitals. The hospitals house their own physicians. There is no formal referral relationships between the private practitioners and the hospital physicians. The patients who visit the hospital directly usually are the very ill or have suffered from external injuries, severe burns, coma or drowning. When the illness is considered mild or chronic, a great majority of the population falls back on the traditional way of self-treatment using home remedies as on the mainland of China.

In addition to Chinese herbs, there are large quantities of over-the-counter Western drugs available in the well-stocked drug stores. For example, in 1970, the city of Taipei had a population of 1,700,000. There were 1,862 Western-trained doctors, and 1,090 pharmacies that stocked a wide range of Western medicine. Since the FDA control is somewhat limited to narcotics and poisoning drugs, many potent Western drugs are readily available without a prescription. The sale usually is promoted by television advertisement. Therefore, in a normal household in Taiwan, the medicine cabinet (instead of storing herbs as in Mainland China), is complete with a large variety of Western drugs for various symptoms such as headaches, cough, cold, indigestion, constipation and diarrhea as well as antibiotics for fever, vitamins for health, hormone pills for youth and strength. In the drug stores, there are untrained store personnel who would be more than willing to give advice to the customer. Thus, the patient may select medicine according to his own dignosis based on television commercials or from the advice of the drug-store attendants. Only when the therapy fails, then will the person go to a Western trained doctor for treatment. If there is no improvement after changing three or four doctors, this person will go to the hospital.

A small percentage of the population may consult a herbal doctor or an acupuncturist first. In the majority of cases, the Chinese doctor will be consulted if the Western trained doctor suggested some form of therapy that the patient did not like. If surgery is recommended, the patient, even if he

The practice of the masses falls into a similar pattern. In a study by Topley in 1969, twenty Chinese mothers were interviewed: the findings were that when their children were sick, the mothers sometimes took them to modern Western trained doctors, also sometimes treated them themselves on the basis of knowledge acquired from kinsmen and neighbors, usually elderly persons. In addition to this, they sought advice from shops that sell Chinese medicine and traditional doctors, even horoscope readers and priests. Sometimes combined medical (herbal) and ritual treatments were given. The contents in their medicine box of the women interviewed has four kinds of items. The first was traditional drugs, such as "Po-ying taan" (Protect Infant Pills) to strengthen the health of the baby, herbs for diarrhea and vomitting, medication for boils and other skin conditions. The second category of items were oils and ointment for various minor discomforts such as headache, stomachache and toothache. The third category was modern medicine including penicillin ointment, iodine and other preparations for wounds, aspirins and cold preparations. The fourth category was the modern form of herbal medicine produced by the factories in Mainland China. These were traditional substances packaged to look like modern medicine, with the formula and instructions printed on the outside of the container. This form of medicine is more convenient for oral administration as traditional herbs usually have to be brewed for several hours before they can be taken. As one may see, the pattern of medical care seeking in Hong Kong is almost identical as that practiced in Taiwan and to a certain extent, in the Mainland China. In fact, this is the common pattern practice throughout Southeast Asia.

The Chinese Student in the United States

One can understand the frustration of students coming from the countries mentioned in the above geographical areas when they discover that the drug store will not advise or sell drugs that they have some knowledge of (such as penicillin tablets or tetracyclines), that they must go to a physician in order to get medicine, and the medical terms are not usually included in their vocabulary. Most students are not acquainted with the idea of health insurance. In Chinese culture, one does not talk about illness or death when one is in good health, as it may bring about bad luck. So buying health insurance out of a very tight budget is a very foreign thought. Therefore, a great many students take a chance of not being covered by health insurance. When one is ill, one tends to treat oneself or consult with a friend. Most of the students carry some home remedies and exchange them with friends. Therefore, a well planned introduction to the medical system of the United States should be part of the essential information available to all the new students admitted to American schools. Proper guidance should be

is well-educated and may visit Western trained physicians for diseases in general, would be inclined to consult a Chinese traditional doctor and hope for a less drastic management. This practice again falls into the general pattern of "shopping for the right doctor". Each patient may visit two or three doctors before submitting to an operation. If is is a malignant case, many more doctors will be consulted, and when the Western trained doctor suggests surgery, radiation or chemotherapy, many patients will turn to herbs to secure a prescription that someone claimed was handed down from generations in the same family. It is important, under this dual medical system, for the government to make greater efforts to standardize the practice of traditional Chinese medicine, and only through research and studies can the two types of practices be truly integrated. Then patients will not fall into the gaps created by non-communication of the two systems of practice.

HONG KONG

The official medical system in Hong Kong follows straight British regulations. All government hospitals, which are usually very crowded, provide free medical service to the people. Private practice is allowed and a good proportion of Western trained doctors work in the private hospitals and clinics. The traditional Chinese doctors are not officially recognized and require no registration except as owner of a business. Under the Sino-British Treaty for the cession of Hong Kong island, one of the proclamations stated that the Chinese were "secured in the free exercise of their religious rites, ceremonies, and social interests..." Chinese traditional medicine is practiced under this auspice. The proportion of doctors may be illustrated by 1971 figures. Early in that year, more than 2,000 doctors of Western practice were on the medical register, with more than 400 unregistered doctors, mostly working in government services and exempted from registration. However, there are a large number of practitioners practicing under the guise of "Chinese practitioners" or "Herbalists". Sixteen associations were listed in 1971, with an estimate close to 3,000 members. Many herbalists with no formal medical training, practice the combination of modern and Chinese medicine. In 1966, there were approximately 4,000 shops and stores in business selling or dealing with Chinese herbs and medicine. This shows the practice of Chinese medicine is as common or even more popular than in Mainland China and Taiwan.

There were 200 registered and government pharmacists and numerous drug stores selling Western medicine. The drug control is relatively restricted but most of the antibiotics and potent drugs can be obtained without prescription. The availabililty of the dual system is quite similar to Mainland China and Taiwan.

provided when one is ill, and information on all the health facilities should be obtainable. Some understanding of the background of the health system practiced in countries where the students came from may help strengthen the support of student advisers and assure the students a safe and sound life in the United States.

THE HEALTH CARE SYSTEM OF KOREA

by Chai Bin Park, M.D., Dr. P.H.

Traditional Medicine

In Korea, underneath the veneer of vigorous modernization processes, traditional medicine does not show any sign of waning. Modern medicine was introduced barely a century ago, but traditional medicine has lived with the people for thousands of years. Concepts of illness and behavior of healing with traditional medicine are probably more agreeable to the people of Korea, especially for those less educated or living in rural areas. Considerable portions of the people perceive that the cost of folk medicine is much more reasonable. They may even feel that the professionals of Western medicine are alien to them.

Even some of the highly educated Koreans consider that traditional medicine is superior in dealing with certain types of ailments, such as chronic diseases or functional disorders. On the other hand, even those practicing folk medicine accept new medicine in areas such as, surgery and chemotherapy. Thus, today the two systems of medicine coexist in Korea, if not cooperating or supplementing each other.

There are several different types of professions in traditional medicine, as in modern medicine. The oriental medical doctor (OMD) is in the top echelon. They diagnose and treat patients based on the principles of Ying-Yang and Five Elements. Since the liberation from Japan, the status of OMDs has been elevated to the same legal status as doctors of Western medicine. They now have their own medical schools of six years and their own hospitals. There are efforts to systemize traditional medicine and integrate the two systems of medicine.

Acupuncture, moxibustion, bone-setting, and massage are also considered professional health activities of traditional medicine. To practice in these areas, governmental licenses are required. Superstitious forms of healing are frequently observed. Geomancers, fortune-tellers, especially shamans, perform this type of healing. Shamans (mudang) are not well educated and not particularly respected but they are an important source of health care for rural people. A Western physician reported that on an island near Seoul with 100,000 people, they had only 17 physicians and less than 10 OMDs, but it had a mudang association with well over 100 members (Sich, 1978). The mudang's healing ceremony, kut, lasts several days and is always well-attended by neighbors. For the government health planners and modern physicians, traditional medicine may not exist, but it will exert a

profound impact on the health care of the general people at least for some time to come.

Facilities

By Asian standards, Korea's ratios of medical facilities and personnel to population are not bad and they are getting better and better. Rather than sheer numbers, the problem is with the distribution between urban and rural areas. For instance, in 1983 there were a total of 12,724 medical facilities. Over 85 percent of them were in cities which had 60 percent of the entire population.

Of late, large hospitals have shown a tremendous increase. Until the middle of the 70's there were less than 40 general hospitals but by 1980 there were 80, and 1983 they increased to 138, suggesting a rapid change in the pattern of seeking and providing medical care. The number of medical offices and clinics are only slowly increasing; in 1983 they reached the level of 7,000; representing an increase of about 15 percent in the past decade. Dental clinics and oriental medical clinics showed little changes until recently. However, they now present relatively fast increases, reflecting the graduates of new schools. In 1983 there were 2,462 dental clinics, a 6 percent increase over 1982. Midwifery stations, operated by part-time midwives in their own homes, have been decreasing; in the middle of the 1970's there were more than 700 such places, but in the early 80's there were less than 500. Most of these medical facilities belong to the private sector. There are about 550 persons per hospital bed.

A nationwide health center network is in operation. There are 218 centers, one in each county (gun) and minor city, and also in each district (ku) in the metropolitan cities. In the lowest level of the rural administrative unit (myun), there is a subcenter. There is a total of 1,361 subcenters in the nation. In each subcenter there are three health aides supervised by a doctor to look after maternal and child health, tuberculosis and family planning.

Personnel

There are about 27,000 physicians with about 5 percent annual increase. The population-physician ratio is exceeded by Japan, Singapore, and Hong Kong in Asia. The government expects that by 1998 there will be an oversupply of physicians. Dentists started to increase only recently; they still number less than 5,000 and the population-dentist ratio exceeds 9,000 to 1. There is a large number of pharmacists, about 1,000 more than physicians. All these professionals are predominantly working in urban areas. Nearly 45 percent of the physicians are in Seoul. Physicians are generally practicing at privately owned clinics (about 40%).

Although there are abut 50,000 licensed nurses and 5,500 midwives, probably about one-third of them are actively working. Women's working lives are short as they usually retire when they marry. Each year about 3,000 new nurses are added. Midwives began to increase from 1980 reversing the past trend. These nurses and midwives with six months training are mostly employed in remote villages to provide primary health care as community health nurse practitioners (now over 1,100).

Health aides assist nurses and doctors in hospitals. Since 1968 they are employed in health centers as tuberculosis and family planning workers. They require 9 months training after finishing at least junior high school. A tremendous increase of this category has taken place since 1970 when West Germany began to employ them. In 1971 there were nearly 9,000 health aides and by 1983 the number grew ten-fold. Also fast growing are the medical technologists. They grew from 2,500 in 1970 to 15,000 in 1983.

In the area of traditional health care, the officially licensed are rather small. Since 1980 the OMDs are growing by about 100 per year. However, there are still only 3,500 OMDs. Masseures number more than 2,500. There are 200 acupuncturers and 105 moxacularies. Despite the opposition from OMDs and pharmacists, the government began to license herbal druggists in 1983 for the first time in eight years. Newly licensed were 590 herbal druggists and they were placed in villages without pharmacists.

Costs

Medical care has been overwhelmingly provided by the private sector. Until 1977, when the medical insurance plan was first initiated by the government, health care costs have been almost totally financed by the individual households on a fee-for-service basis. Studies indicate that in 1975 the total health expenditure was W7,000. The implementation of the insurance program in 1977 has spectacularly increased health expenditures. In 1979 the total expenditure rose to 3.4 percent of the GNP, corresponding to per capita expenditure of $15,861. Of this, out-of-pocket payment amounted to 83.3 percent.

The 1982 national survey of the Korea Institute for Population and Health presents the prevalence of sickness during a 15 day period to be 136 per 1,000 persons with a per capita medical expenditure of W2,204 or approximately $2.80. Translated into an annual basis, it amounts to W52,896 or slightly over $66.00. This is also equivalent to an expenditure per household of W223,000 ($279) and an expenditure per patient of W388,000 ($485). The survey also indicates that the expenditure tends to increase in the rural

areas, contrary to general expectation.

A phenomenal growth in the coverage of medical insurance has been observed. In 1977 the coverage was less than 9 percent of the population; in 1979 it grew to 21 percent, in 1981 it was 30 percent, and in 1983 it became 38 percent. A great majority of policy holders are the wage workers who are provided with medical care under a public assistance program (Medicaid). Thus, now about one-half of the entire population are covered by insurance and social security plans. Unfortunately, those self-employed and living in the rural areas are not covered by these programs.

The 1970's statistics show that 90 percent of births were delivered at home attended mostly by mothers, mothers-in-law or "experienced" elderly ladies. But the 1982 national survey indicates that in the urban area only 21 percent and in the rural area, 64 percent of births are now home deliveries. Still, the vast majority of home deliveries are attended by non-professionals. Babies are mostly breast-fed. Bottle feeding is only about 5 percent and the combination of breast and bottle makes up another 7 percent.

The handicapped and mentally diseased are discretely hidden because they are considered a family disgrace. Among the less educated, the entrance of ill-spirits to the body is sometimes regarded as the cause of mental disorders. As against an estimated number of 64,000 patients who required institutional care, there were only 4,000 beds available.

Though dietary habits are changing lately, the majority still think that a meal must include rice. Any other food is considered as a "side" dish to rice. The consumption of animal protein is quite limited but there are very few malnutrition cases. Fermented vegetables (kimchee) are eaten at practically every meal. Women in puerperal state are supposed to eat large quantities of seaweed soup.

HEALTH CARE IN SOUTH ASIA:
BANGLADESH, INDIA, NEPAL, SRI LANKA

by Walter K. Patrick, M.D., M.P.H., Ph.D.
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Introduction: The Geographical Context

The major geographical areas of reference will be Nepal, India, Bangladesh, and Sri Lanka. Among these multi-national, and rich mix of cultures and traditions, there are some common but limited trends which may provide some general indicators for health seeking behavior, continued compliance, and anticipated outcomes. The countries are essentially characterized by the Hindu-Buddhist traditions of the Indian subcontinent interwoven with the influence of Muslim and Arabic modalities of medicine. Its vitality and rate of growth in this region and the consequent negative effects on traditional medical systems is also remarkably persistent in these countries, though to a lesser extent in Nepal.

Generalizations and Trends

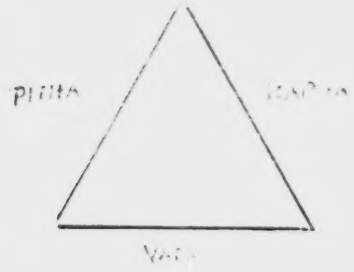
The magical, religious, and scientific derivatives in health care pervade the South Asian region and are manifested in major degrees of overlap between the traditional health care systems: Ayurveyda, Unani, and Folk Medicine. Out of the Hindu tradition and the vedantic scriptures (3000 B.C.), Ayurveydic medicine, first as an expression of early folk practices and herbal medicine, grew later with experimentation, testing, accumulated experience, and wisdom of thirty centuries into a composite body of science and art of caring and healing.

Ayurveyda. The practice of Ayurveydic medicine is therefore more than a medical system of care. It is closely linked with the culture and belief systems of people -- not merely the health belief aspects. This involves their common view of the universe, of obligations and reciprocal relationships with each other and the healer, expectations for the future and appeasement of the unknown. The nature of pain and disease, and especially positive notions of health related life styles, all form a holistic fabric into which the diagnostic and treatment process of the Ayurveydic system is woven.

Ayurveyda is made up of the root words Ayur = life, and veda = knowledge or science, and denotes the science of life in its component parts -- body, senses, mind, and soul -- and their functional union. The major emphasis and perspective is to promote and maintain health (positive health) through

life style practices, diet and exercise. In illness management treatment, considerations include involvement of significant others, work capacity, dietary habits, and social and mental consequences. The treatment process is often a herbal preparation applied locally or taken internally and the preparation and ritualization of the treatment steps have symbolic meanings reinforced by the physician-healer interaction.

Pathogenesis of disease in the Ayurveydic system is conceptualized as an imbalance of the three body humours -- Vata, Pitha and Kapha, or due to dissonance among interacting psychic factors such as Satwe, Rajas and Tamas.



The Tri Dosha Theory in Ayurveyda

The characteristics of the three body humours that control all bodily functions are (1):

(a) Vata equaled to the pervading vital initiating element in the body (sometimes loosely stated as "wind"). Persons with a vata constitution are said to be ectomorphic with a labile affect and are predisposed to nervous and functional disorders(2).

(b) Pitha is the energizing principle and is concerned with maintenance of body heat. The personality type characteristic of pitha constitution is the mesomorph with associated tendency to develop circulatory disorders.

(c) Kapha is the bonding complement of tissues and organs and is represented by mucus, the excess of which presents a phlegm. Endomorphism is the main feature of the body type commonly represented by excessive kapha, and arthritic conditions predominate the clinical picture.

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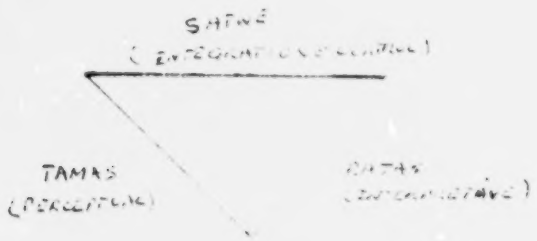
In addition to the main body types there are transient forms as well as combinations of the three basic body types.

The concept of Mental Illness is rooted in the Indian Samkya philosophical system where Purusa or spirit is the passive principle while Prakrti, the primodal matter takes form as the dynamic force in the evolution of the egoconsciousness and the intellect.



Interactions at Psychic Level

The derivative of ego or self consciousness is Satwe which controls Manas or the conscious mind, the sensory and the motor organs. At the functional level the interaction of the Tamas (the perceptual) and Rajas, the interpretive pathways finds expression in the tammatras or subtle elements of sound, touch, color, taste and smell. From these attributes, the elements of the Universe - wind, fire, earth, water, and ether - take shape as a response to purusa, or the spiritual component. Thus the extension of the mind into the phenomenal aspects of the world flows naturally in the Ayurveydic system.

The Ayurveydic system recognizes the ability to change the psychic constitution for example through Yoga, The mind is conceived as in a continuous state of agitation like the sea. The disturbance from the outside is through the sensory stimuli, and internally through memories of emotions and drives. The purpose of yoga, stated simplistically, is to reduce this turbulence and produce a tranquil state of mind by reduction of sensory input as well as emotional impulses. Yoga posture and breathing exercises have demonstrated the capacity to alter physiological and humoral states favorable to health (e.g. reduction of pulse, respiratory rates, changes in cortisol excretion as well as in blood pressure

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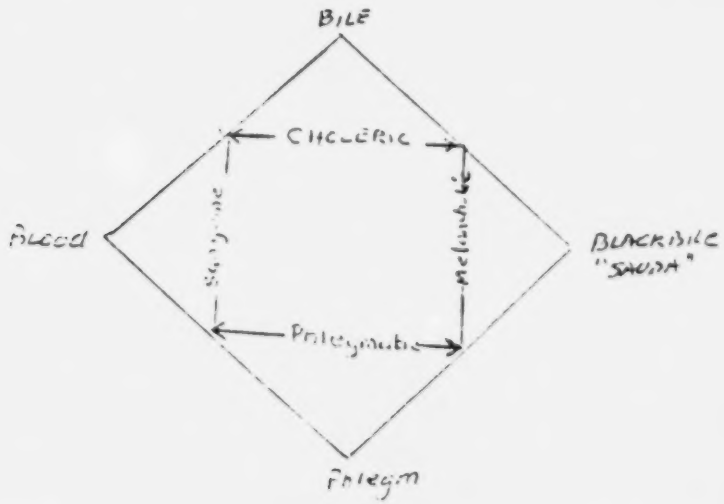
have been recorded) (3). The karmic principle of birth and rebirth and the continued cycle of existence until the "bad" actions of a previous birth are obliterated by suffering or illness also plays an important role in how persons perceive illness, suffering, and compliance with treatment.

Unani Medicine. Unani Medicine is derived from Arabic (4) medicine and has developed from the refinement of plant products for treatment as well as the use of more purified chemical and metallic substances for medicinal purposes. It combines the Greek tradition in medicine with the Islamic influences in medicinal chemistry spurred by experimentation during the period of alchemy. However potent the medical intervention an overriding belief in a supreme being is implicit in the expressed capacity of healers to combine medical and spiritual powers. In this form of care not unlike other traditional forms, the physician-patient relationship is to some extent influenced by religious beliefs and reliance on supernatural forces. In rural Bangladesh, Pakistan and Muslim areas in India, Unani Medicine assumes the prevelant mode of health care delivery.

In the Unani system four body humours and their interactions are postulated in the causation of disease. The humours and the combination of their characteristics are represented:

Blood has properties hot/moist (sanguine)
Phlegm has properties cold/moist (phlegmatic)
Yellow Bile has properties hot/dry (choleric)
Black Bile has properties cold/dry (melancholic)

Medications are given to restore the imbalance between these humours, and therefore themselves have the 4 major features.



HUMORAL BALANCE IN UNANI MEDICINE

Folk Medicine. Home remedies are commonplace in every society and more so in traditional societies in the developing world where the healer and the family and the larger community often participate in the preparation and use of medications.

The influence of folk healers is maintained through their close affinity with the community and as the care process involves identification with local customs in food habits, concepts of hot and cold, birthing practices and other expressions of cultural activity. The spiritual, religious, and metaphysicl aspects of their healing adds another dimension to their acceptance.

Some Major Health Problems of the Region

The communicable diseases like malaria, diarrheal diseases like cholera, hepatitis, and childhood upper respiratory infections, constitute a major part of the morbidity in these countries. However the non-communicable diseases such as cancer, cardiovascular diseases, accidental injuries and mental health problems are becoming increasingly important causes of mortality and morbidity. For example, the average incidence of tuberculosis in the region is estimated at 100/100,000 (7) having fallen from a figure well over 300 some twenty years ago. Even though the mortality due to the infectious diseases are falling, the morbidity trends are slower to decline. Diseases related to environmental factors such as malaria, cholera, hepatitis; those related to stress, dietary habits, and lifestyles like accidents, suicides, hypertension; and those consequent to socioeconomic conditions creating malnutrition are the common health problems seen in these developing countries. Biological and genetic causes of illness are seen and are of significance to some ethnic groups (drug sensitivity, genetic deficits, etc.).

Health Care Facilities

Health care in rural areas of the region is predominantly provided by traditional providers -- Ayurveydic, Unani and folk healers -- ranging from about 90% in Bangladesh and Nepal to about 55% in Sri Lanka. In cities and towns the allopathic or Western practitioners provides relatively more health care (e.g. 65-70% in Sri Lanka) but still a major segment of the poorer segments and older populations seek traditional health care services.

These countries in the South Asian region, which were former

British colonies, have inherited aspects of the British colonial medical system. The capitals and major cities have large University type hospitals, while the regional capitals have general (8-10 specialty) hospitals. At the provincial/district level the hospitals usually have the 4 basic specialty services: Medical, Surgical, Obstetric, and Pediatric Units supplemented by visiting dental, opthalmologic, and ear, nose and throat services. The rural hospital/maternity home has out-patient services for medical/surgical patients and maternity beds. Where municipalities exist outpatient care is supplemented by towns and villages. Councils have considerable emphasis on traditional healing practices.

Modalities of Treatment

As discussed earlier there is a pluralism in utilizing particular forms of care. A patient in the course of an illness may seek care initially from the Ayurveydic physician, and switch for advice or treatment to alternate providers. Acute emergencies requiring interventions of a surgical nature tend to be channeled towards the Allopathic (Western) system, while chronic and terminal conditions seem to shift towards the traditional modalities of care (5).

Hospital Patterns in the Region:

1. Capital/Regional/Hospital -- 600 - 1000 bed hospital
2. Provincial -- 200 - 500 " "
3. District -- 80 - 100 " "
4. Rural Hospital -- 20 - 80 " "

The distribution of institutions, and staff, like doctors and nurses, and services, are mainly in the urban areas of high population density.

Costs

The cost of medical care is increasing considerably in the region, even though hospitalization for serious illness is provided at no cost for the poorer populations. Public servants, service personnel, and a small proportion of workers in the private sector are provided with free health coverage. However, these category of persons would prefer to seek care at private institutions but cannot afford the costs of care. They therefore often obtain services in seriously overcrowded outpatient departments at provincial and district hospitals or are admitted to crowded and underequipped institutions that service patients generally in open wards. The cost for a private outpatient consultation would amount to an average day's wages (blue collar) and the cost of seeking the services of traditional practitioners is rising faster than that of Western practitioners. This is especially so in countries like Sri Lanka as in the treatment

of mental illness through traditional "thovil" ceremonies.

Summary and Generalizations

The pervading value system of the region can be generalized in terms of:

1. The belief in forces beyond the natural in determining health outcomes.
2. Rationalizing behaviors to fit the Karmic principle of desire, suffering, and rebirth.
3. Fatalism and lack of control over one's own destiny and course of life events including illness.
4. The validation of illness by significant others and the traditional care providers (traditional birth attendant, folk practitioners, etc.)

The credibility and status of providers varies considerably, the hereditary-expert combination being the most acceptable, symbolized by Ayurveydic doctors gaining skills in Western Medicine. The other end of the scale would be folk practitioners whose influence and perceived value is often dependent on their charisma and religious affiliations.

Concerns about major life events such as birth and death are viewed as part of a cycle process (Karma). The high infant mortality in some countries like Bangladesh makes people delay naming their infant until after 30 days. The rituals associated with delivery -- burial of placenta considered the sibling of the infant; feeding of the mother with special herbs and avoidance of foods such as leafy vegetables, small bony fish, believed to adhere to the uterus after partus; and other social practices tend to reinforce health care seeking behavior from traditional systems like traditional birth attendants rather than the Western system of care.

Hot and cold foods are classified as regards their propensity to increase body heat and lower it with associated manifestations -- flushed skin, rash, etc. In a diseased or weakened state the effects of these foods are considered to be even more potent and are deemed to create further imbalance among the humors. The rationale in management is to neutralize "heaty" conditions with "cooling" foods, for example the viral rashes -- chicken pox, measles, etc. are best treated by giving cooling foods like milk, yogurt, cucumber, etc., with avoidance of heaty foods such as prawns, eggs, and egg plant.

Implications for Student Advisors

1. The close relationship with the Arurveydic/Unani Physician, who shares a common value and belief system is often lacking in a new environment and therefore active listening to identify differences in perceptions

of the problem is important.

2. Diagnostic procedures need to include adequate and appropriate analysis of history, perception of illness, and presenting symptoms to elicit other dimensions of the problem.

3. Language barriers and differences in concepts of illness may distort the problem and hence cultural interpretation through use of country specific or culture specific interpreters may be necessary.

4. The student counselor therefore begins to serve as a bridge between the student seeking care and the provider who may have to be briefed about the special needs and problems in formulating treatment strategies.

5. The social support network is often lacking, or the supportive network may lack relevance. The adviser may have to serve as an interim link, or significant other and provide building an effective network.

Guidelines for Foreign Student and Health Advisers

Area of Assessment	Indicators
1. Besides economic constraints what other factors are important.	May be what type of care/services was he/she most satisfied with earlier.
2. Nature of the social support network.	Identify significant other(s) and determine cultural similarity to ill person so that they can help interpret the language and symbolic meanings of the expressed symptoms.
3. Relevance of network and capacity to link with needed persons.	Barriers to linkage within an apparently homogeneous culturally similar group. (e.g., social taboos, trust, control)
4. Selection of provider	Appropriateness not only in terms of competency, and costs, but also with regards to their capacity to relate to foreign

	student and his/her concerns. Female clients may prefer a suitable setting/ female provider.
5. Holistic/comprehensive	Determine need for referral to primary care provider for screening or follow up (Gatekeeper or Manager of care process).
6. Utilization of services	Assess extent of "overuse" (# visits, costs, # of days) as well of degree of utilization. (Missed appointments, services.)
7. Compliance with treatment regimens.	Determine satisfaction with services, and completion of treatment schedules and problems associated with them.
8. Use of preventive health services.	Identify referral care groups to these services: Dental, Family Planning, Immunization.

CHARACTERISTICS OF BURMA'S MEDICAL/HEALTH CARE SYSTEM

by the Burmese Students in Hawaii, October, 1985

Health Care System

The people of Burma have considerable faith in the practice of indigenous medicine especialy if the doctors are from well-reputed schools of traditional medicine. The Burmese people tend to take traditional medicine more often than Western medicine in cases of indigestion, dizziness and catching colds. Especially in rural areas, some practices of Western medicine may conflict with their traditions and beliefs of the people.

Facilities

The current medical facilities are provided in government run hospitals and a small number of private clinics. Government medical establishments include teaching hospitals, general hospitals and specialized hospitals in which free consultation services are extended to the people. Even in private clinics, the cost of consultation fees are low compared to Western standards. Workers can get treatment from workers' hospitals or from clinics run by the Cooperatives Ministry. Here the members pool their resources to set up the clinics. When treatment is needed, the workers pay for medicine and surgery, but there are no additional consulting fees. This is more like the medical insurance system in the West.

Personnel

To be qualified, doctors must earn the degree of MBBS (Bachelor in Medicine and Surgery). After that they can go for further specialized studies or work in public health and primary health care. Nurses have to undergo 3 years training at a school of nursing and mid-wives for one year. Community health volunteers include auxiliary midwives (6 months training), community health workers (21-30 days training and yearly reorientation), and traditional birth attendants (30 weeks training and life long experience).

Values and Beliefs

Birth

Birth is regarded as the first stage in the reincarnation cycle. The Burmese, unlike the other Asians, are not disappointed when a new-born baby happens to be a girl. Burmese women enjoy 3 months leave as their maternity benefit, having the full amount of their salaries. Giving birth at a hospital will cost about 1,000 kyats (U.S. $125.00) in urban areas, but at a local town hospital the

expense will be half of that.

Death

The Buddhists believe that everything is mortal and are prepared to die peacefully. They have to earn good merits in life to be reincarnated in a better life. They want to spend their last minutes of life at home among the family. They usually take treatment at hositals but when they know that they have to die, they turn to religion and are prepared to give up their life peacefully. The Burmese people, regardless of their faith, regard death as inevitable and a natural stage in life.

Hot and Cold Foods

Burmese believe in the effects of hot and cold food for different climates and situations (pregnancy). Some of the vegetables (like cucumber) may be thought of as cold food and considered unacceptable in certain periods. Pregnant women do not take hot and spicy foods.

Failure

People rarely commit suicide at times of failure because of their faith in religion. One out of 100,000 people commit suicide in Burma. It is a major sin according to religious teachings. When they face failure and humiliation, they may enter the priesthood to get away from society and to have a better reincarnated life, but they do not accept suicide as a solution.

Health-seeking Behavior

Literacy is very high in Burma. Health instructions can be found in newspapers, periodicals, and journals and also on radio and television programs. In the wake of epidemics (like cholera) the government issues warnings and instruction and special health teams are sent to the crisis area to come to grips with the epidemic. Abortion is illegal in Burma and most people are ignorant about sex education. Pre-marital sex is totally unacceptable in Burmese society.

Mental Health (Emotional Health)

One mental hospital exists in Rangoon where psychological treatments are available. The rate of mental cases are increasing due to socio-economic factors. The government is establishing medical centers in various part of Burma to provide treatment and rehabilitation programs for drug addicts because Burma has many victims of drug abuse.

The World View

The average Burmese has strong faith in the Western ways of medical treatment. They would not be reluctant to undergo a surgical operation. However, people in remote areas may have some traditions that are not compatible with Western medical treatment. Due to limited exposure to the hustle and bustle of Western life, the Burmese lead a less complicated and less stressful life.

TIPS ON HEALTH CARE FOR INDOCHINESE STUDENTS

by An T. Nguyen, M.P.H.

Traditional Views of Medicine

The Indochinese are past oriented people, their beliefs go from generation to generation but they are receptive to ideas and techniques which may be advantageous and effective. Vietnamese patients usually make their choices between folk medicine practices from China or the latest medical treatment from the West.

Vietnamese usually try to explain their illnesses by looking for natural or supernatural causes, or disharmony in the body. A natural cause would be a person having an upset stomach from eating some rotten food. This upset stomach can be cured by family remedies such as taking medicinal herbs or following special diets. Supernatural illnesses such as mental disorders may come because the gods or spirits are punishing a person who violates some religious or ethical code. The cure for these problems lie in the use of charms or exorcism ceremonies performed by a priest. Disharmony in the body comes from the Chinese belief in which the human body operates in a perfect balance between "am" (yin) and "duong" (yang), or hot and cold. A person who is in good health is in perfect harmony between hot and cold. Any disequilibrium leads to discomfort or illness. A person exposed to too many "cold" elements such as, walking in the rain without a raincoat or eating foods classified as "cold", will end up sick.

Certain foods are classified as being "hot or cold". Vegetables and fruits, along with fish, duck and others things which grow in the water are classified as "cold" but fruits like mangoes, longans etc., are "hot". Most meat, spices (like garlic, ginger, onion), and sweets, are "hot". Tea is "cold", but coffee is "hot". "Hot" foods and beverages are believed to strengthen one's blood; consequently, after surgery or child birth, "hot" drinks are preferred and "cold" drinks are avoided.

Related to the belief of balance is the "phong" or bad wind. A stroke is due to bad wind. Hives or leprosy are "phong". Beef and seafood carry "phong". In this context, "phong" may be a form of allergy. One should be very careful in the consumption of food in order to stay away from illness.

To combat minor illnesses like colds, indigestion, or "phong", Indochinese often carry with them some oil or ointment like Tiger Balm, Burma's Cula with methol or eucalytpus base which can be rubbed under the nose, on the temples, on the stomach, or even taken by mouth. Many

supposed to be exposed, even in private.

The Western physician is unquestioned in his decisions and the patient, plays the role of a passive recipient. Public health nurses who do the follow up for Indochinese refugees at a Honolulu Health Center for pulmonary tuberculosis, complain that Indochinese have many questions in mind but never have the courage to ask the doctor when he carries out the treatment or during consultations. However, later on, these patients may reduce the drug dosage by themselves, shorten the length of treatment, or refuse to take medication completely.

Improving Services In The U.S.

There are many cultural differences and difficulties in communication between the American health providers and the Indochinese. While the Indochinese appear polite, look calm, and seem content, they may in fact be facing a crisis. Even the barriers to communication create a lot of anxieties and frustrations.

Not all Western medicine is recognized as effective for the Indochinese. Sometimes religious healing applies very well to mental illnesses especially those who suffer from culture shock, loss of family members, friends, or social status, isolation due to language barriers, and the feelings of guilt from being the "survivor". These feelings lead to anxiety, depression and sometimes paranoid reactions. Indochinese people may feel that the nightmares are omens of pending disaster. This then leads to more anxieties. Attempts to avoid nightmares by staying awake may bring these patients to American doctors with complaints of fatigue and insomnia.

Ways to improve and facilitate the communication may improve understanding. A medical bilingual dictionary may help in this matter along with a good bilingual interpreter. Pamphlets with simple explanations of the problem would help. Compassionate service from the American health providers and foreign student advisers, like talking with respect and consideration of another person's feelings, will definitely help to assure good relationships.

HEALTH CARE IN THE CULTURAL SYSTEM OF INDONESIA

by Agus Suwandono, (doctoral student in public health,
University of Hawaii at Manoa)

Background

Indonesians are basically of Malay heritage and are divided into approximately 300 ethnic groups, which speak about 365 languages and dialects. Bahasa Indonesian is the national language. In excess of 90 percent of Indonesians are of the Islamic faith. The rest are Christians, Hindus, Buddhists and other religions. Although Indonesians have these modern religions, traditional beliefs have pertinent influence on their lifestyles.

Modern Health Care System

In Indonesia, public health facilities are operated by the central government as well as by communities consisting of a network of primary, secondary and tertiary facilities. However, the principal source of modern public health services for the 120 million Indonesians who live in rural areas is the primary-level system of health centers (HC), subcenters and mobile unit centers are under the technical responsibility of the Directorate General of Community Health. HCs provide basic medical care, maternal and child health, family planning services, communicable disease control, immunizations, hygiene and sanitation, nutrition, community health education, school health services, dental treatment, community health nursing, mental health, and simple laboratory work. It is also responsible for recording vital statistics and health information reporting.

Curative services in general, including hospital and HC services, are not free of charge, except for those who could prove that they are not able to pay legitimized by the village head man. The HC charge per one visit is Rp. 150 or approximately 13 cents (US$).

The health insurance system is only provided for government officials and some private or business employees.

Traditional Health Care System

The traditional health system refers to those practices and beliefs which are largely accepted by the people in rural areas of Indonesia. They are essentially a unique collection of common sense remedies and supernaturalistic ritualisms that have been handed down from generation to generation in order to deal with disease and illness. Moreover, the diverse cultural values among hundreds of ethnic groups of Indonesian people have given rise to a variety of traditional health care practices.

In antiquity, people believed that health was a state of being free from the curse of God. Today, spiritual sanctions are used as a means to discipline and Indonesians grow up in a world dominated by spirits which affect them even as adults. Spirits are believed to dwell in all natural phenomena; therefore, volcanos, mountains, winds, and rivers are believed to be capable of being pleased or offended.

All humans are believed to possess spiritual powers, but those more adept at communicating with the supernatural serve as traditional birth attendants, traditional healers and bone healers, etc.

When people get sick, there are six possible actions for them to take: 1) No care or no treatment; 2) Self-treatment, for example, scratching themselves by using a coin, buying medicine and so on; 3) Finding traditional medicine practitioners who use herbs, massages or other forms of traditional treatment; 4) Finding traditional ritual practitioners who use white or black magic; 5) Going to traditional modern practitioners who use accupuncture or accupressure or other electromagnetic equipment; and 6) Going to modern practitioners such as doctors, nurses, HCs or hospitals. In rural areas of Indonesia, most sick people choose among the first four of the above. About 31% of deliveries in urban areas and 87% in rural areas of Indonesia are still performed by traditional birth attendants. Roughly 87% of the patients from the Central Java rural areas had been seen by traditional healers before admittance to the hospital (1977, Santoso, et al). Rienks, et al (1980) in their anthropological survey in Banjarnegara, Central Java, found that when rich people get sick, first they would go to the HCs, hospital, doctors or nurses. Then they would go to traditional practitioners when the modern practitioners could not help them. On the other hand, middle class people would go to the traditional practitioners first, and then to modern practitioners. However, the grass roots level community would go to the traditional practitioners one after another.

A society or a tribe may have more than one medical system overlapping. Tradition is also often associated with religious beliefs which affect the traditional medicinal system of the society or tribe. There is at least one traditional healer and one traditional birth attendant in each village of Indonesia. Hence in Indonesia, the traditional system holds a stronger influence in rural areas than the modern medicine system. The communities make this choice because traditional health practices are integral parts of Indonesian culture. The concepts of health and illness cannot be separated from people's cultures, religions, beliefs, taboos, myths and legends.

The Janavese Banyumas people believe that the balance among

the three elements in a human (human organs, human god and spirit) and the connection between the human as a microcosmos and the universe as a macrocosmos will result in welfare, health and happiness. If there is no connection between the macro and the microcosmos, and/or there is an imbalance among the human elements, there will be illness, disaster and death. There are 2 kinds of illness, first, the simple illness or "lara mriang". It is caused by an imbalance among the human elements. Second, serious illness is caused by an imbalance or no connection between the macro and the microcosmos, or "lara nemen". There are several categories of "sawan". They are caused by inadequate guidance by the parent during the transition of the infant from the womb to tangible reality. "Kewalat" is misfortune, unhappiness or illness in an older child or adolescent because he offended his parents. "Kesambet" involves, in one way or another, the disturbance of an evil spirit. (Rienks, A. and Iskandar, P.)

In Bali, there are basically two traditional healing methods commonly used. The "ketakson" healing method is based on spirit or power from the macrocosm. The "usadha" healing method is predominantly derived from an ancient palm leaf manuscript called "rontal usadha". It is a textbook of their traditional medicine which has been greatly influenced by the Ayurvedic medicine of Hindu India.

In South Sumatra, the people believe that illness is caused by one's own parents' sin, magic, or God's will. To redeem one's own or parents' sin and reconcile it, someone has to make a ceremony using the traditional healer as a priest.

In Kalimantan, diseases are related to the supernatural and magic power. For example, "kasarungan" means someone's normal behavior is changed by an evil spirit which possesses a person. "Ketulanhan" is an illness caused by trespassing the parents, power by denying them or acting against them. "Kepuhunan" is an unhealthy state that is caused by the refusal to eat food served by a local host. This can be a spirit that lives in a big tree, an awkward stone, a creek, or a cemetery.

In Irian Jaya, volcanoes, mountains, winds and rivers are believed to be capable of being pleased or offended. They still believe that the spirit can help them avoid illness, disaster or death. They still pay homage to stone statues and wood statues in order to receive a good harvest.

In Sulawesi, the causes of illness are supernatural, natural or of unknown origin. Disease is caused by "sagala" or God's will, "cika", "semeng-semeng" or priest's words and "soke", "doti-mata" or sorcery.

Cultural System

The Indonesian culture is a mixture which developed from different cultures that had already existed indigenously and that were brought to Indonesia by people from many different countries since the beginning of its history.

The social structure of Indonesian life is determined largely by the ethnic group and their predominant pattern of life involving sidely separated agricultural villages. The formative period of ethnic groups and cultural patterns in this archipelago has been taking place for untold ages. In the book entitled "Netherland Indie", J.D. Furnivall observed that many peoples migrated to Indonesia, each assimilating its predecessors or driving them to take refuge behind sea barriers, hilltops, or in the dense jungles of the larger islands. This process allowed different patterns of local dialects and cultures to develop. He further pointed out that "through long ages, the peoples of this archipelago slowly built up a common Indonesian culture, elaborate and distinctive, and so stable that when, after years, new currents flowed in from Hindu, Chinese, Moslem, and European life, it could adapt and absorb these alien influences without losing its distinctive character". There is much diversity, but broadly speaking, it is diversity in unity.

The influence of religion is an extremely positive support, especially for the health development program, but in certain situations it may be reduced to a negative, hindering factor if treated incorrectly. The Indonesian population is predominantly Muslim. Islam itself is a very influential religion, not only mentally, but also physically which has a powerful meaning for health and social welfare. Islam clearly describes health, nutrition, sanitation, personal hygiene, clothing, bathing and washing, sexual intercourse, and brotherliness regarding good social living standards and welfare. The core of the "ayats suci" or "sharia" openly and descriptively explains to every Moslem how to treat himself hygienically and how he should help his neighbors with advice, education and material contributions. However, most Indonesian people grow up in an atmosphere dominated by spirits and this atmosphere influences the people to bind themselves to spiritual life. Hence some people pay homage to Allah, or God, while at the same time they also remember their local spirits or beliefs as a part of Indonesian culture which is adopted in depth and is passed from generation to generation.

Another cultural factor which influences health is the term "nrimo" (Javanese) or acceptng one's fate. A sense of cohesiveness, slow decision-making and working, having too much self-esteem to receive something as charity, and paternalism are other cultural aspects which are very important to be considered in the behavior of Indonesian

people, especially for rural people.

Taboos still exist in some Indonesian communities. These taboos have an important influence in the field of health and nutrition. For example, children cannot eat too much meat because it will cause skin disease or worms; girls cannot eat a certain variety of bananas and eels; pregnant women cannot eat shrimp, meat, and certain types of fruit. Another taboo is that, under certain conditions, parents cannot cut their children's hair before 6 years of age. These taboos still exist in the rural areas of some parts of Indonesia. There is a common concept of culture in mutual self-help called "gotong-royong". This applies particularly to cooperatives within each community and one finds all members of a village assisting each other, i.e., in the planting and harvesting, construction of roads, houses, and so forth. The second positive concept of common culture is called "rukun". In cases of conflict, the guiding principle is to find a reasonable solution which will result in no resentment between the Indonesian villagers. The third common cultural concept is called "musyawarah" or deliberation, where every community decision is the result of joint deliberation. Another tradition which is deep rooted in Hinduism is the "selemantan". It is extended by someone who intends to request the blessing of God for himself and his family members or to thank God for His blessing to him or his family members. He invites his neighbors to pray together in his home (usually at night) and this is followed by having dinner together. The host commonly will serve his guests the best food possible. Specific "slamatan" are: "sunatan" (circumcision) and "lebaran" (Muslim New Year).

Indonesian Students Who Are Studying in the USA: A Discussion and Suggestions

It has been mentioned above that traditional medicine has been a part of the Indonesian's culture. Moreover, the Indonesian communities always reflect their own culture to their lifestyle, attitude, behavior and their feeling. However, it should be remembered that many of the Indonesian students who are studying in the United States or other universities around the world are educated Indonesian people. Most of them are government officials or private organization employees. They have already obtained health insurance either from the government or from the organization for which they work. They are usually from the cities where there are health facilities for using their health insurance. Although the hospitals and HC facilities in Indonesia are not as sophisticated as those in the United States, students already know how to use health insurance and the procedure of using health insurance cards. In Indonesia, however, the differences are as follows: a) as health insurance card holders, patients do not need to make appointments to see the doctor if they have any health problems except when they

choose the most famous doctors; b) all of the families are covered by the health insurance program, but in the U.S. some of the sponsored student's families are not covered by health insurance programs. Hence, some of these students without any health insurance will have a lot of problems when their families get sick; c) in Indonesia, the health insurance card holder can go directly to the specialists, but because of the bureaucracy in most U.S. hospitals, students have to get a referral slip first, before they can meet specialists; d) in Indonesia even if people only get influenza, the doctor will administer a shot or give them several kinds of medicines, hence some of the students are really surprised when they do not get any medicine from the doctor but only advice such as drink a lot of juice, take a rest and so on; e) dental problems are not covered in most university type health plans and going to the dentist is very expensive, (in Indonesia, dental services are provided for health insurance card holders); f) several other classical problems are different health terminologies, difficulty in expressing the symptoms of a disease because of language problems.

In Indonesia, the Department of Health has recognized that some traditional medicine can be very useful in promoting health and curing illness. The 29th WHO Assembly has recommended action to encourage the development of traditional medicines where it is appropriate. Thus, there are still Indonesian students who use traditional medicine according to their tribe's belief to cure or to protect themselves from diseases, physicl disorders, or psychological problems.

One thing that should be taken into consideration in dealing with Indonesian students or other foreign students is psychosomatic problems. These problems are caused by stress because of different cultures, food, lifestyles, educational systems and interactions between teachers and students. It usually happens to new students. The problems of the English language often make the students feel frustrated and will result in psychosomatic problems. It should be remembered that some of the students have difficulties adjusting to their new environment. Some students who live without their families may feel these frustrations more intensely.

One small thing that sometimes makes the Indonesian student uncomfortable is the TB test. Some students have a positive reaction in the TB skin test, but most of the x-rays show negative picture. It should be known that all Indonesian students were given BCG shots, that according to public health experts, give a false positive on the TB skin test. It should be noted that all Indonesian students who are sent by the Indonesian government have already been examined physically. However, some of them have to be examined again in the United States and unfortunately they do not have their family doctor.

Here are some suggestions that may be useful in helping Indonesian students deal with health problems:

1. Explain to them about the health care system in the U.S. and its differences with the Indonesian health system.

2. Try to develop a discussion that makes either the professor or the student understand each other's cultural background.

3. It should be remembered that psychomatic problems are common among the students and a little support may be very useful for them.

4. Don't blame the students if they believe in traditional medicine.

5. There is an Indonesian Student Association in the U.S. (Permais), which can be consulted in case of any Indonesian student's problems.

MALAYSIAN HEALTH AND CULTURAL BELIEFS

by Farida H. Che Din, B.A., M.P.H.

Traditional medicine is still popular among the rural population of Malaysia. Medicine men called "dukun" are often consulted for minor ailments, fractures, sprained ankles and for treatment of those affected with evil spirits. For curative purposes, the medicine men heavily use herbs, plants which are proven to have medicinal value (e.g., use of certain herbs to reduce blood pressure). Similarly certain traditional healers treat patients affected by "evil spirits".

There are several types of traditional healers existing in Malaysia. The "patients" are mainly the rural inhabitants but people from urban areas also consult the traditional medicine men. Apart from treating "patients", medicine men have the capability of preparing amulets for young infants and even for adults in order to ward off the "evil spirits". Certain medicine men are experts in treating those with sprained ankles. The method of treatment is through prayers and the use of special ointments to massage the affected area.

Health/Medical Facilities

Malaysia is divided into East and West (Peninsular) Malaysia with a total of 13 states. There is a wider coverage of health services in Peninsular Malaysia compared to East Malaysia. In the rural areas, there is a rural health unit which covers a total population of 50,000 people. There is one main health center, supported by 4 sub centers and 20 mid-wife quarters. The three-tiered system is now replaced by a two-tiered system, i.e., with a Health Subcenter and the Community Clinic (Klinik Desa). In every district in the state, there is a district hospital and in major towns, there is a big general hospital. Generally, there is a low percentage of underserved areas.

In East Malaysia, health services provide limited coverage due to the geographical structure of the two states of Sabah and Sarawak. There are mountains in the center of both states and health services are inaccessible for many people. This problem is ameliorated by mobile clinics and the flying doctor service. However, these services are still inadequate.

The services provided are family planning, child health care, prenatal and postnatal services, immunizations, environmental sanitation, communicable diseases control, food quality control, malaria, TB, and Hansen's disease services. Utilization of services is high.

The personnel in medical care are the physicians, nurses, sanitation workers, pharmacists, public health engineers, food technologists, nutritionists, health educators, laboratory staff and others. In spite of the three existing medical schools, Malaysia still has a shortage of physicians. To overcome the shortage of skilled manpower, the government hires foreign physicians on a contract basis.

In government hospitals and clinics, the services are free or sometimes the patients are requested to pay a nominal fee for medication. There is no necessity of medical insurance for the people because the government provides health services. However, the cost of treatment by private physicians and hospitals is fairly high. The low income group normally utilize the government clinics and hospitals, while the higher income group normally use the the private hospitals.

Values and Beliefs

The Muslim community restricts eating and drinking and abstains from certain activities like gambling, cheating, etc. during the important and holy month of Ramadhan. From the health point of view, Muslims are not permitted to:

- take or give blood slides during the fasting period
- receive any intravaneous injections of any kind
- donate blood

These restrictions have tremendous implication for compliance issues and for carrying out laboratory tests. Muslims normally feel tired, weak and anemic during this period; this also has an effect on the students' work performance.

Post-Natal Period (After Delivery)

Mothers need to adhere strictly to the various food taboos. Taboos are based on the "hot" and "cold" theory. Certain foods are classified as hot, cold or having "wind". Generally, mothers are forbidden to eat vegetables and fruits which are classified as cold. Post-natal taboos are still widely practiced. This is clearly the influence of the older upon the younger generation. Cooling foods such as cucumbers and pumpkins are not given, as they might cause chills or lockjaw. Only small amounts of water are permitted because drinking excess water is thought to cause post-natal bleeding and "swelling of the muscles". Eggs are not given as they are believed to cause discharges of pus. Hot foods are not so numerous as the "cold" foods and are generally considered less dangerous.

Death

Death is viewed differently among the different races. To the Muslims, death is something which has to be accepted by family members. Muslims believe that the time has come for God to take away life. A Muslim who passes away in the Holy Land of Mecca is said to have received a special reward from God for all the good deeds the deceased had done in his life.

There are several ceremonies following the death of a family member. Certain religious rituals have to be followed by the family members within one week, 40 days, 100 days and every year. Among the Muslims, it is a religious rule that the deceased have to be buried, if possible within 24 hours.

Among the Chinese and Indians, the rituals are different following the death of a family member. The Chinese normally keep the dead body for nearly a week before burial or cremation. Throughout the whole week of the mourning period, there will be a priest who will conduct religious rituals and food will be served to the guests. The grieving family is required to wear black clothes a period of one year after the death of a close family member. Unlike the Chinese, the Indian widow has to wear a white saree following the death of her husband. The burial period for the Indians varies from one day to a few days.

Health Seeking Behavior

Generally, the urban people are relatively aware of the importance of the early detection and treatment of diseases. Frequently, the people may consult close friends about their health condition and see the physician or specialist immediately. There is a general tendency to consult specialists instead of general medical practitioners. However, there are still problems of non-compliance with the treatment regimens especially among chronically ill patients. On the other hand, rural people tend to seek the advice of close senior family members and village leaders before seeking medical attention. The elders in the family, for example grandparents, uncles and aunts are generally viewed as important decision-makers in the process of seeking medical help. There is an apparent shift in seeking Western forms of medicine as compared to the traditional methods of treatment. Education may be one of several underlying factors for the increasing awareness of Western medicine.

Family Planning

This is a rather sensitive issue among various ethnic groups in Malaysia. Religion can be a strong determining factor influencing the acceptance of family planning. Generally, Islam permits birth control methods except permanent

sterilization. There are several criteria, including medical reasons, under which permanent sterilization may be permitted.

In the urban areas, there is a general trend toward having smaller families. In view of the high cost of living, working parents, better education, difficulty in finding babysitters and less domestic help, there is a tendency to space and have smaller families. In the rural areas, there still are extended families, and the families are generally large, but with more education there is a gradual change from large family to a small family unit.

THE STUDENT FROM THE PHILIPPINES

by Divina A.R. Telan-Robillard, B.S.N., R.N., M.P.H.

The Filipino who comes to the United States to study will have very distinctive features. He will be dressed smartly, if not trendily, in appropriately coordinated clothes. His grammatically correct English may reflect ever so slightly the accent of the region of his origin. His pleasant but deferential manner will make one conclude of his better-than-most education and quite correctly, his middle class background.

This picture most graphically represents the fact that the Filipino student who comes to the United States comes from a country which has a literacy rate of 89.7%, one of the highest in the world. The Philippines is also a country where the language of instruction, business, legal and even everyday shoptalk is unabashedly English. Furthermore, the urbanity and apparent cosmopolitan nature of the Filipino student in the United States can also be adequately explained by the fact that most, if not all, institutions for higher learning are located in metropolitan areas. Given the high premium accorded by Filipinos to education, many young Filipinos fresh out of high school trek to the cities annually in search of the pathways to social mobility and recognition. Thus, it is often the culture of these cosmopolitan areas which is more pronouncedly displayed by the students in the United States rather than their so-called Filipino-ness.

Nonetheless, some Filipino values do surface in social interactions and in so far as they have considerable influence on behavior, particularly in helper-client relationships, merit thoughtful anticipation and recognition. There are two assumptions, though, that need be to put forth beforehand regarding the nature of these values: 1) these are value systems found in the lowland Philippines where the majority of the popultion resides and 2) the Filipino claim to these values is not unique; but what makes them "Filipino" is the special emphasis and pervasiveness which are given them by Filipinos.

The significant values that will be discussed are:

1. reliance on personal networks for emotional and social support

2. "hiya" (shame or losing face)

3. "bahala na" (fatalism)

4. desire for interpersonal harmony

5. physical modesty

Reliance on Personal Networks for Support

Personal networks occupy a very important niche in the Filipino's array of coping resources. It is documented in a recently concluded study (Caces, 1985) that personal networks are more readily relied upon by newly arrived than on institutions for assistance. These networks include not only family members but also ritual kinsmen and friends of friends (no matter how unknown such contact is to the person himself). Mutuality of acquintance sometimes is enough to establish a contact practice before a Filipino leaves for any place to recall and communicate with all this "kilala" (known contacts). A "kilala" would feel obliged to accommodate the needs of the new person and thereby establish a system of reciprocity between them. For instance, the contact provides housing for the person who would then help in the performance of household chores - this is a system of favor trading called "utang na loob".

Thus, when a Filipino student is in a tight spot, it is reasonable and probably, prudent on the part of the counselor to expect that such support system exists and is operating in favor of the student. Given such a situation, getting to know these sources of support (their strengths and constraints) and working closely with them would be very helpful.

"Hiya" (Shame of Losing Face)

Personal honor or "amor propio" is high on the list of inviolables among Filipinos. In traditional Filipino society, the individual is seen as an extension of the family. Personal honor is likewise intertwined with that of the group's. This state assures that any personal achievements or failures ultimately rebound to the group thus, determining its status in the larger community. Therefore, the presence of an honor student, a son who made it to the States or a runaway in a family, acts as a barometer of the individual family's social standing. The importance given by families to honor or esteem so develops in the individual the obligation to uphold such sentiments that personal failure in terms of shame or losing face is intolerable.

To a certain extent, this explains that enormous temerity with which some Filipinos deal with apparently simple and harmless tasks like talking to a professor about clarifications on a project, raising a point in a class discussion, or making an appointment over the telephone. Occasions where "failures", for example, in terms of reprimands, rejections or being laughed at, are anticipated

Physical Modesty

To the blase' American, the Filipino would seem prudish when he refuses or is hesitant to shed clothes in the presence of others. A Filipina will unconsciously press her hand against the top of her blouse when she stoops to pick up something. This physical modesty is related to the fact that gym locker room experiences are alien to most Filipinos. In the barrios where privacy afforded by personal rooms is luxury, Filipinos have evolved the graceful capacity to slip in and out of clothes without being ever at any instant without sufficient cover. Hence, this value should be given consideration when physical examinations or inspections are in order.

Conclusions

Every helper-client relationship will evolve its own unique characteristics despite the redundant human problems that it seeks to understand and/or solve. The Filipino student as a client will have quirks and features which are universal as well as distinct, such as those combinations which brings to fore his adherence, consciously or otherwise, to "Filipino" values. Undoubtedly, recognizing/understanding these values and their impact on behavior will contribute to the development of a successful helper-client relationship.

HEALTH AND CULTURE IN THAILAND

by Chamnan Prasertchoung, M.D., M.P.H.

There is a variegated network of traditional medical practitioners and traditional health practices which are integrated into Thai cultural patterns. These services are utilized by about half the population. This reliance on self-medication and traditional practitioners is especially predominant in rural areas where other health services are either not affordable or not acceptable to the people.

Health Services in Thailand

Health services are provided by both the private and public sectors. The private sector has concentrated on curative medicine, the dissemination of information, and the provision of family planning services. There are 3 major groups in the private sector:

1. Private hospitals: 25-40 beds
2. Polyclinics, mostly in Bangkok and most of them are specialty, same day surgicenters.
3. Solo private clinics run by on General Practitioners mostly at provincial or district levels.

The cost of services is very high in the private sector (2-5 times more than government service). The curative services provided by the private sector are particularly significant and prominent in Bangkok and the 126 municipalities of the country. Health services of the public sector are concentrated in the provincial areas. Bangkok also has 39 private hospitals of over 25 beds, to only 25 in the rest of the country. There is a great disparity in favor of Bangkok's five million people with regard to the scope and quality of medical services available.

Payment for Medical Expenses

The government health services are free of charge for the eligible poor. In general, Thais usually pay for their own health care. They can seek services from drug stores, private clinics, private hospitals or government health services. The poor are eligible for free treatment. The government servants and their families have the benefit of a refund for the full hospital costs of using government hospitals and a partial refund for private sector use.

Thai people normally prefer the private sector to the government sector because of short waiting times and the relative ease of making appointments with the doctor. Government servants usually go to the government health

services because of the full refund.

Major Values and Beliefs

Doctors

The Thais expect that doctors should be:

1. Highly intelligent people
2. Have high medical ethics
3. Be very helpful for the sick
4. Have high socio-economic status

Death

Of all the life-cycle rites (birth-sickness-death), the Thais consider the "ngarn sop" (cremation ceremony) to be the most important. Funeral rites mark not only the end of life, but the start of the journey towards rebirth. Death is seen as a transition, a natural and necessary part of life.

Birth (rebirth)

The precise moment of a baby's entry into the world is a key factor in Thai fortune-telling. "Karma" of past lives causes an individual to be reborn in a certain situation, in a specific place and at a precise time.

Fever

In rural areas, the sick person with a fever is prohibited from drinking cold water and cold food.

Pregnancy

Pregnant Thai women are traditionally bound by many taboos which, among other things, prevent them from fishing, eating chilies, telling lies, or visiting the sick and attending funerals.

Stress/Anxiety

Nowadays, Thais in urban areas frequently have stress and anxiety because of their socio-constraints. They will usually consult their close friends at such times. Otherwise, they will go to buy tranquilizers at the drug store. In general, they usually get better in a few weeks. One of the most widely used phrases in Thailand is "mai pen rai," which means it doesn't matter or never mind. The phrase signifies the Thais desire to keep relationships peaceful and on an even keel, to shrug off the little frustration and disagreements of life, and to prevent anger and passion from coming to the surface.

Failure

Thais have a tendency to avoid unhappy or emotionally charged situations, and the anxieties of preparing for the future or lamenting the past cause the Thais to live mostly in the present and to enjoy above all the present moment. They rate highly the desire and ability to have a good time, "sanuk". Attending a temple festival or visiting a fair is "sanuk;" chatting with neighbors and friends - a very popular pastime in Thailand is also "sanuk".

Sometimes when they have a serious problem and cannot solve it by themselves, they will go to the temple and sit down and keep their mind quiet, "tum chai hi sa-ngob" or "chai yen", in order to release problems by meditation.

Mental Health

There is a psychiatry section in the medical department of each provincial hospital and 10 subregional mental health centers scattered in each subregion of Thailand.

The World View

At the base of Thai culture is the predominant religion, Theravada Buddhism which has had a profound influence on Thai art, culture, traditions and learning. Today over 95% of the Thai population are Buddhists. The order of Buddhist monks remains a major social instituition in Thailand.

HEALTH CARE FOR MICRONESIA STUDENTS

by Donald H. Rubinstein, Ph.D., M.P.H.
University of Hawaii

As this handbook goes to press, Micronesia and the U.S. are in the midst of finalizing their political relationship. The resulting status of Micronesia -- and the consequent level of financial support and other forms of foreign assistance to Micronesia -- will have a major impact on all aspects of health care, as well as the ease with which Micronesians may enter the U.S. for study or work. Foreign student advisers should apprise themselves of the new political status of Micronesia as it takes form.

"Micronesia" refers to a multicultural region in the western Pacific. The population is miniscule (120,000) and the total land area vanishingly small (about the size of Maui), yet scattered across an ocean expanse the size of the continental U.S. Within this region are ten major cultural groups (Belau, Yap, Outer Islands, Truk, Pohnpei, Kosrae, Pingelap, Mokil, Marshall Islands, and the Polynesian atolls of Kapingamarangi and Nukuoro) and numerous minor dialectal and subcultural divisions. Although each major culture group speaks a separate language and follows different patterns of behavior and social organizations, they all share a similar colonial developmental history. The year 1985 marks the centennial of formal colonial control of Micronesia, first under Spain, then Germany, followed by Japan, and finally America.

During the 40 years of American rule, a Western system of health services has been installed, chiefly in the "port-town" areas of densest population and infrastructural development. Small hospitals (averaging 75 beds) exist in each area, and are staffed largely by Micronesian medical officers (M.O.s) trained in Fiji; Micronesian medics and nurses trained in-country; and a small contingent of American and Filipino M.D.'s and hospital administrators. In general, these hospitals are beset wth serious problems of inadequate funding, staffing, supplies, and grossly unhygenic conditions. As result, the local populations are reluctant to utilize these services, except as dispensaries for minor medications, and only as a last recourse for more acute medical problems, after non-western remedies have been tried. Outside of the port-town centers, Western medicine is only minimally available, in the form of small, outer island dispensaries, often lacking electricity or water. These dispensaries serve mainly as first-aid stations for treatment of minor ailments.

National health insurance plans are now under consideration

or experimental introduction but are not fully adopted in Micronesia. Medical care is provided free by Micronesian health services, and serious cases requiring complex diagnostic, surgical or rehabilitative care are routinely sent to Guam or Honolulu. This system of introduced Western medicine has placed priority on expensive, highly technical, acute interventive care, rather than on basic sanitation and primary prevention. In one of the Micronesin states, for example, over half of the national health budget of $2.6 million (for a population of 35,000) is absorbed by medical referrals off-island, and by maintaining seven hemodialysis patients in the center hospital; meanwhile over half of all reported deaths are children under five, and 92% of outer island children are unvaccinated, even though epidemics of pertussis and polio have occurred in recent years. The introduced system of Western medicine is not designed for primary preventive health needs of this dispersed, rural population.

Indigenous medical practices and beliefs persist throughout much of the population, despite the lack of acceptance -- or indeed the active discouragement -- of traditional medicine by western-trained practitioners in Micronesia. Herbal remedies are widely used for treatment of bleeding, swelling, muscle pain, headache, skin and eye irritations, as well as minor internal ailments such as diarrhea, constipation or cramps. Therapeutic massage and bone-setting techniques are used to treat fractures and sprains. Indigenous midwifery methods are also effectively practiced. Knowledge of indigenous medicine is rather widely distributed throughout the population, at least among the older generation of Micronesians, rather than restricted to a small class of specialists. Individuals seeking treatment tend to consult relatives who are medically knowledgeable.

Indigenous belief in disease etiology ascribes it largely to social and supernatural sources. The maleficent effects of interpersonal hostility, gossip, and jealously are believed to produce serious illness. Similarly, the unappeased anger of ancestor spirits or other supernatural figures is thought to be common cause of illness. Pervasive belief in magic and sorcery as primary agents of illness is widespread, though Western theories of disease causation may be accepted as secondary explanations. These beliefs affect health-seeking strategies, since Western remedies may be felt to be inapplicable to the real causes of the illness.

Another factor affecting Micronesians' willingness to seek Western medical care and counseling is the issue of medical confidentiality. In small face-to-face communities in Micronesia, gossip and public shaming are important forms of social control, and consequently, personal matters are guarded carefully, especially when the subject may be a cause for social stigma, as in the case of some illness or

disability. Micronesian students should be reassured on the issue of medical confidentiality, in order to encourage them to seek needed counseling or medical attention.

Nutrition level and protein intake in Micronesia are quite adequate in communities still reliant upon subsistence gardening and fishing. In urbanizing port-town centers, however, there is a rising prevalence of malnourishment, especially in younger children, owing to parental neglect, poverty, and ignorance of nutritional needs of children. Diets of white rice, cola and other "junk" foods are common among many port-town families, and these dietary habits frequently are followed by Micronesian students in the U.S. Obesity and associated cardiovascular disease and diabetes are increasing rapidly among urban-dwelling Micronesians by their mid-thirties.

Among young Micronesian men, the heavy consumption of beer is often part of a recreational pattern of almost daily gathering to "talk story" and socialize, with occasional all-night or all-weekend drinking sessions, frequently marked by rowdy or violent behavior. Trouble with police, injuries from fights, and drunken accidents often result, and consequently Micronesian young men have achieved notoriety in many college towns in the U.S. More tragic is the growing number of Micronesian students returning home with head injuries and other permanent disabilities from drunken brawls and accidents.

The gregariousness of Micronesian students, and their sense of responsibility to each other, make them especially vulnerable to peer expectations and influence. A group of Micronesian students sharing a room or a house can all be made to suffer because of one problematic individual -- for example, an ex-student who has failed or dropped out, and is drinking heavily and borrowing money from the others. Yet the others are likely to endure the disturbance rather than confront and remove the offender. Therefore, foreign student advisers to Micronesians should fully understand the student's living situation, and appreciate the potential of this situation to affect the student.

In some parts of Micronesia, the rate of suicide among young men is extraordinarily high (ten times the U.S. rate for young men). Typically, these suicides are triggered by conflict within the family, and are not related directly to school problems or failure to achieve chosen goals. Yet in counseling Micronesians, foreign student advisers should be aware of the potential for impulsive suicide, especially if the student is living with close Micronesian relatives in the U.S. Advisers should also be sensitive to the different communication styles they may encounter among Micronesians. Avoidance of direct eye contact, hesitating and quiet speech, and long-delayed responses may express respectful and humble

THE HEALTH CARE SYSTEM OF PAPUA NEW GUINEA

by Georgeda Buchbinder, M.D., Ph.D., M.P.H.

It is useful for those involved in counseling students from Papua New Guinea on health related matters to know that there is more than one health system in that country. There is a national system, developed with the help of the Australian Colonial Government beginning after the Second World War and continued with some modifications by the present government. This system is based on Western or cosmopolitan beliefs about disease etiology and treatment. The care provided by this system is delivered by personnel of various degrees of sophistication who have been trained in Western style training institutions, many in Papua New Guinea. The system is supposed to provide comprehensive primary health care to all citizens of the country, both rural and urban, through a hierarchical system of aid posts, health centers and district hospitals. Although the system has been plagued with breakdowns in supervision and logistics, it has been remarkably successful in reducing morbidity and mortality, particularly in the rural areas where over 80% of the population resides. This is perhaps because many of the diseases which cause much of the mortality and morbidity in Papua New Guinea can be effectively treated by simple means. Most health services, particularly in the countryside, are provided free or for minimal charge. There are beginning to be some physicians in private practice in the towns who charge fee-for-service. This system of primary health care is relatively new and is still in the process of evolution. However, it is important to remember that it is superimposed on a multiplicity of indigenous health systems.

Papua New Guinea is characterized by an extremely difficult terrain that has been responsible for the isolation of its population, not only from the outside world but from each other. This isolation has led to both linguistic and cultural diversity and, as might be expected, to diversity in indigenous health systems. It is impossible to describe them all and any generalization will have its shortcomings, but some elements of indigenous health beliefs and practices are held in common and are sufficiently distinct from cosmopolitan beliefs and practices to warrant description.

Traditional Papua New Guineans know nothing about the germ theory of disease although in many respects they act as if they did. They will avoid drinking contaminated water, and they will, if they can, avoid places of high mosquito density in the evening. If asked why, they will talk about spirits and ghosts that have the ability to cause illness.

For the most part in these traditional societies, disease and death, particularly among young productive adults, is not a

random event caused by environmental pathogens. Instead it is usually viewed as a punishment by vengeful ancestral ghosts for digression of proper social conduct or by capricious spirits, or by sorcerers or witches. In any case, it is necessary to determine, usually by some sort of divination, the cause of the illness.

Once this has been determined, a course of action can be mapped to affect a cure. This cure may involve a number of sorcerers or witches. These divinations and rituals are usually performed by shamans who are known to possess special attributes. If disease is thought to be due to the displeasure of ancestral ghosts, it may be necessary to sacrifice a pig to appease them and to return the victim to his or her usual state of health. In the highlands in particular, it is frequently the ghost of one's parents that kills. In other parts of the country it is the fear of sorcery that is paramount. Besides these "magical" and ritual cures there are a number of simple physical and herbal means for the treatment of various maladies and discomforts. These vary from place to place.

Papua New Guineans are by and large an extremely pragmatic people who are quick to accept new ideas when they perceive that they have merit. At the same time religious beliefs tend to persist. So much of indigenous thought about health and disease centers around religious beliefs and ideals about social relationships and obligations that these ideas are bound to persist to some extent even in individuals who are continuing their education abroad. Thus, it might be wise, if illness develops in a Papua New Guinean that does not easily respond to treatment, to enquire about his feelings of guilt or persecution. It may be necessary to set the social order right.

III.

The American Health Care System

THE AMERICAN HEALTH CARE SYSTEM: ITS ORGANIZATION AND OPERATION

by Robert E. Mytinger, Dr. P.H.

Historical Development

Unlike the evolution of health care in most countries of the world, and especially differing from that in developing nations, the U.S. health care system has its origins firmly planted in the private and voluntary sector of society. Governmental health services, which characterize the majority of health services in other countries, arose mainly in the latter decades of the 19th century with the establishment of a national network of state, county and city departments of health.

Consequently, the American system is pluralistic with both private non-profit (often called "voluntary"), private for-profit, and governmental health services operating side-by-side and often in competition with one another. The vast majority of hospitals, of physicians' and of dentists' practices are privately owned and operated, and governmental services represent the minority dimension of American health care. Personal diagnostic and curative health and medical services are nearly exclusively in the private domain, with the governmental services concentrating on disease prevention, health promotion and operation of special hospitals and clinics devoted to communicable disease treatment and mental illness.

The Ways In Which Health Services Are Provided

As suggested above, health services are provided by both private and governmental entities. In the public (i.e., governmental) sector, are departments of public health as the most visible component of the system. In Hawaii, there is a single State Department of Health which serves the total population. Its services include environmental sanitation, health education, the maintenance of vital records (such as births and deaths, marriages and divorces), public health laboratory service, and a limited amount of clinical, medical, and dental care aimed at pregnant women, infants and young children and school-age chidren. Akin to other health departments, the Hawaii State Department of Health operates special hospitals for the chronically ill, those suffering with tuberculosis and leprosy, and those who are mentally retarded and mentally ill. Another example of governmental health service would be the University of Hawaii's Student Health Service which, while operated by an entity of the state government, is unrelated to department of health services.

The majority of health, medical and dental services are provided privately. Hospitals are, for the most part, "voluntary" community hospitals, owned and operated by private, non-profit corporations or religious orders. A growing number of hospitals (such as Kahi Mohalu for psychiatric care and Straub Hospital for general hospital service) are owned by private, for-profit corporations. The vast majority of medical doctors, and nearly one-hundred percent of dentists are private practitioners, providing their services through private offices and clinics, and through fairly large multi-speciality medical group practice clinics. The so-called "solo" practising physician and dentist is the majority, and their private offices are located in medical office buildings, shopping centers and in private buildings scattered throughout the community. Most physicians and dentists in private "solo" practice provide general medical and dental service, but some are specialists who limit their practice to a specialized category of illness such as cardiology, urology, orthopedics, and obstetrics and gynecology. The majority of medical specialists, to whom a general physician might refer a patient, are located in the large multi-specialty medical groups in Hawaii which are to be found on most islands. Likewise, the vast majority of pharmacies are privately owned and are located in hospitals, medical clinics, shopping centers and in other general business locations. Drugs are most commonly purchased directly by the patients from a pharmacy with a prescription written by a physician or dentist. It is unusual, except in the case of hospitalization, for a physician's office to directly provide drugs.

Reference to specific physicians, for those who do not have a private physician, can be obtained in a variety of ways. One can ask friends for references, one can be referred through Student Health Services, one can simply choose from the "yellow pages" of the telephone directory which lists physicians by their specialty, one can call the Medical Society and be given a list of 3-5 names but no recommendations, one can approach one of the multi-specialty medical groups such as Straub Clinic, Fronk Clinic, or the Honolulu Medical Group and be referred appropriately within the medical group, or in Hawaii one can obtain from the Hawaii Medical Service Association its list of "participating physicians" who are doctors and dentists who have agreed to a certain minimum fee schedule.

The Ways In Which Health Services Are Paid For

There are three major ways in which medical services are paid for in the American system. One is through governmentally supported services which tend usually to be free-of-charge to the recipient of service. Such service tend to be quite categorically narrow (except for such general services as

in HMO's than in the indemnity plans, the overall impact on the patient's pocketbook is substantially less overall.

The Way Health Services Are Organized

The organization of the American system can best be understood when it is divided into "ambulatory" and "in-patient" services. Ambulatory services (i.e., those for the non-bedfast patient) are available in free-standing clinics, in hospital out-patient departments and in centers of various types, including surgery centers. These tend to be "open to the public," on an appointment basis in most instances, and represent "medical stores" at which individual patients may "shop". As with many other stores, each has different prices and charges, each will have different waiting times for appointments, and of course each offers a different medical or dental practitioner.

In-patient services, on the other hand are provided by several types of "medical institutions". The most frequently observed is the hospital, most of which are classified as "general" hospitals -- that is they serve general medical and surgical needs. A frequently (and inappropriately) used feature of general hospitals is the Emergency Room, which uninformed patients use as an after-hours physician's office. This is inappropriate because the physicians who staff emergency rooms are usually specialists and are not general physicians, and also because the charges are exceedingly high and often only meagerly paid for by insurance plans. The other in-patient services of hospitals include medical and surgical bed care, pediatric bed care, and obstetrical and maternity bed care. The hospital can be viewed essentially as a "medical hotel" which provides mainly (in its charge to the patient) room and board. The physicians who serve hospitalized patients are privately practising physicians for the most part, and the laboratory, x-ray, physical therapy and other ancillary services are provided by semi-private entities which operate the hospital-based service. Thus, in some ways the American hospital can be viewed as a "shopping mall" for the bedfast patient, with various unrelated providers catering to the individual patient's multiple needs, and rendering individual and separate bills for their services. There are also specialty hospitals, such as the Kapiolani Medical Center which caters exclusively to obstetrical, maternity and pediatric care, the Rehabilitation Center of the Pacific which offers long-term physical rehabilitative care, the Shriner's Hospital which provides orthopedic services for children, and Kahi Mohalu which provides in-patient psychiatric care. Little used by younger persons is the extended network of "long-term" care hospitals and institutions, which include hospitals for chronically ill persons and those with communicable diseases such as tuberculosis and leprosy, skilled nursing and intermediate nursing facilities which provide long-term nursing care to

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patients no longer in need of the full range of general hospital services, and a variety of care home for persons who are in need of minimal medical and nursing supervision.

Because the field of hospital service has become quite competitive, most hospitals offer not only the full range of in-patient diagnostic and therapeutic service, but the services are nearly identical between one hospital and others. Hospitals are increasingly being induced by government and private insurers to limit patient length of stay, and it is uncommon today for patients to be retained by the hospital for more than an average of about 5 days. This results in patients being discharged by the hospital (upon their physician's order, of course) before they feel "totally well" in many cases, and it is increasingly common that post-hospital arrangements in the home or in another type of medical facility are needed by patients to complete their convalescence.

IV.

Preventive Assistance and Health Care

PREVENTIVE ASSISTANCE AND HEALTH CARE

by Nancy Stockert, M.S.W., Ed.

INTRODUCTION

Culture Shock and Stress

Most personnel working with foreign students are aware of the term "culture shock". Briefly, the student enters a society in which language, communication styles, values, food, dress, and social interactions are different and even incomprehensible compared to their home country. There is a sense of disorientation, frequently followed by nostalgic idealization of the home country. If new relationships are not established, the student may become isolated, lonely, and depressed. Even if new friendships develop, they are frequently not intimate because of language or cultural barriers.

The student is in the host country to study and frequently withdraws into studies rather than making any attempt to correct the social situation. On the other hand, those in the host country who have contact with the student frequently do not realize there is a problem until the student becomes ill, fails academically, or encounters some other crisis.

Some students come abroad because they show outstanding academic promise and are under a liberal grant, scholarship or fellowship program. Others have families who can afford the expense of an education abroad. Still others are being sent for more professional or technical training, through their government or employer. However, most students' families have sacrificed a great deal to help their sons or daughters come to the U.S. In any case, all foreign students are under considerable pressure to succeed academically because of immigration requirements, and most students have high expectations regarding their experience in America and a better future for themselves as a result of their stay in this country.

Typically, even American students experience a great deal of stress while attending college or graduate school. They feel that their future may be dependent on how well they perform in school, and yet they are still experimenting with new independence from parents and still formulating ideals and ideas. Foreign students are in much the same situation, with the addition of several elements.

First, foreign students are adjusting to a new culture while pursuing an education. They may have left all support systems at home, and "home" is usually far away. Academic failure means returning home in shame, and social failure may

not be recognized as a problem with a constructive solution. Further, in many foreign countries adolescents and young adults are more emotionally and financially dependent on family than adolescents in this country (Yangco, 1984). Frequently financial distress is part of a foreign student's situation as well.

Students from Asia and the Pacific are extremely reluctant to ask for help with personal problems; thus the most important role of the Foreign Student Adviser is to do everything possible to assist these students in making a health and productive adjustment to the new culture.

Prevention

Prevention efforts have been most successful when they are directed toward students dealing actively with their situation, rather than passively waiting for "adjustment" or "accommodation" to occur. Primary prevention activities, such as general orientation programs which provide information and encourage students to reach out to find friendships, and secondary prevention to assist and refer individuals with minor problems before a crisis develops, should cover the numerous areas of daily life. The following section addresses several topics which are frequently problematic for foreign students, including aspects of functioning which can result in health problems if not successfully negotiated. A health care orientation program is suggested, and there is discussion of preventive counseling and referral for health care. Finally, the specific topics of academics, nutrition, and issues relating to sexual norms and problems will be addressed.

The goal of this section is to give the FSA adequate information and ideas to assist foreign students in general problem-solving, taking advantage of the preventive aspects of the U.S. health care system, and maintaining good health in a new location and culture. Hopefully, the FSA will gain increased sensitivity to the needs, values and expectations of the foreign student.

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need to lose their value system or other aspects of their culture in order to benefit from their stay in the U.S. They do, however, need to be prepared to explain their culture to others to avoid faulty expectations and communication.

6. Making available information and advice on recreation, sports, finances, housing, nutrition, clothing and academic life, (and of course, health care!)

Specific Health Care Orientation

Any orientation program should include a section on the U.S. health care system, as outlined in a previous section of this handbook. Specific reference should be made to insurance plans and the costs of medical care. In addition, concrete assistance can be offered by an introduction to the campus health care facility and other frequently used health care providers, with an explanation of the limits and capabilities of these facilities.

Equally important is information-giving addressed to the expectations of the foreign student. Specific discussion of the possible differences in values, philosophy, and communication patterns involved in health care can be achieved through an exchange of ideas or a question and answer session. The following points can help students avoid misunderstandings and obtain good care:

1. The Western health care system is assumed to be primary in this country. That is, the majority of the native population goes to Western-style providers and facilities. The physician may assume that no other remedies are being tried for an illness, or may very briefly question whether one is taking any other prescription medications. In contrast, foreign students may come from a dual or even triple system, where home remedies, traditional healers, and Western medicine operate together. It is vitally important that the student inform the health care provider in this country if any folk remedies have been or are being used, so unwanted interaction effects can be avoided.

2. Some types of medical regimens may need careful explanation - the Western system of medicine does not always provide quick cures. TB prevention may mean months of medication. Strep throat symptoms may be gone in 24 hours but the infection is cured only after all the medication has been taken.

3. The Western approach calls for the patient to give "informed consent". This means that the provider

ORIENTING FOREIGN STUDENTS

General Topics to Cover

In their book Uprooting and Health, (1983), Zwingmann and Gunn discuss the "inevitable" and the "avoidable" problems of foreign students. Among those classified as inevitable are language difficulties, separation reactions, climate and dietary difficulties, and age-determined problems. Among the avoidable problems are those involving misunderstandings and miscommunications. A carefully programmed orientation for foreign students can reduce the negative impact of some of the inevitable problems, and go a long way toward eliminating the avoidable difficulties. Zwingmann and Gunn propose the following:

1. Discussing the process of "uprooting" and cultural adaptation as a normal phenomenon, a positive process, which if negotiated successfully, allows one to enrich oneself by association with another culture, and to give to that culture the positive aspects of one's native background.

2. Labeling of some of the symptoms of culture shock - loneliness, difficulty sleeping or eating, at times psychosomatic symptoms such as upset stomach, fatigue, or headache.

3. Providing information about aspects of this culture which may be perceived as inadequacies by foreign students, and/or which may result in misunderstandings or more serious difficulties. (For example, people in this culture may seem much more materialistic, rushed, and hypocritical than in almost any other Asian or Pacific country.) "Sharing" in the U.S. is only with permission of the person who "owns" something. In most Pacific cultures sharing is a much more broad concept which includes the fact that many material things are seen as belonging to everyone. The norm of reciprocity exists in the U.S., but is a much more casual way than in Japan, where gifts should be equal in quality and quantity to whatever has been given, and/or take into account the status of the giver and receiver.)

4. Pointing out some of the positive aspects of this culture: material well-being, freedom to express one's opinion, a wide range of acceptable conduct, manners, and dress.

5. Emphasizing the fact that foreign students do not

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may discuss the risks and benefits of a particular treatment, or may offer a choice of treatments. To some foreign students who may be familiar with a more authoritarian position, discussion of choices, risks and benefits may sound more like the clinician is experimenting rather than providing "informed consent". Further, these students may be unaware that they may ask questions, complain, or ask for second opinions.

4. Students should be encouraged to let the clinician know what their symptoms mean in their own country, and in turn ask the clinician to clarify what she thinks about these symptoms.

5. There are some foreign students who may be unaccustomed to nurses doing as many tasks as is the practice here. In many countries, a nurse performs more as a clinic aide, and thus would not be taking the patient's history, checking blood pressure, giving injections, etc. It is helpful to let students know that this is the practice here, and that this does not mean that they are receiving second-class care.

Methods

Recruiting other foreign students to describe their own experiences is a way of giving information in a believable, positive manner. It not only can provide the new student with a contact from his own culture, but it also reassures the student that others have gone through the uprooting or cultural shock process successfully.

As mentioned, an orientation session may include questions and answers in which students ask, either verbally or by anonymously writing down their concerns, about what they have heard or assume about the health care system. Any technique will be of value if it elicits students' expectations, helps them to communicate their usual practices, values, and needs, and clarifies how these needs can be met in this society. This not only gives the FSA important information about individual students and their culture, but also helps students to correct misimpressions and to rehearse their approach to a health care or other provider.

The FSA should be careful not to overload students with facts during an orientation. Facts can be written down and distributed for later reference. Instead, the focus can be on encouraging mutual exchange, presenting onesself as a warm, trustworthy person, and indicating that the facts are available for anyone with questions or concerns. An equally important focus can be on helping students make contacts with other students, whether they be newcomers or "peer

counselors" who have already gone through at least the beginnings of adjustment to this culture.

As part of an orientation program it is also important to arrange a variety of informal, social occasions, so the student will see the FSA as a friend rather than just a representative of the college bureaucracy.

COUNSELING ASIAN AND PACIFIC ISLAND STUDENTS

by Nancy Stockert, M.S.W. and June Naughton, M.A., M.Ed.

"Counseling" in Asia and the Pacific

Professional counseling is still quite unusual in many non-Western countries. Most often, an older family member, religious leader, or friend who is highly respected or trusted gives advice based on knowledge of the person's life situation, family and social background. This knowledge has developed over the years, and the "counselor" does not need to elicit details of the individual's background. The non-Westerner's problem and its resolution are considered primarily in relation to social interactions, within both the immediate and extended family and the larger community.

As opposed to the American emphasis on self-determination and individual fulfillment, Asians are constantly aware of how their actions reflect their responsibility to the family. They generally feel more comfortable talking to people with similar cultural backgrounds, fearing that strangers and official reports may damage their reputation or hurt their families, especially if information about their problems is reported back to their country. Despite this general preference to talk to someone with a simlar background, at times an outsider is preferred. Singaporeans and Hong Kong students speak of the malicious gossip among their fellow countrymen hurting their families. Students from Korea said that teachers have been used to promote pro-government issues and in some cases, are suspected of causing "trouble" to some of the students. Thus, when personal problems occur, Asian students may find it more reasonable to seek medical assistance rather than go to a counselor or to their countrymen. (Zwingmann and Gunn, 1983.)

Pacific Islanders rely on relationships built upon trust, avoiding trouble to those whom they do not know. There is sometimes a demeanor of calm , an aloofness, which gives the appearance that they have no problems which in fact may not be the case. The Pacific Island student may attempt to establish a relationship by visiting the counselor and discussing general topics. If a feeling of trust does not develop and hints of problems are not responded to with specific offers of help, the Pacific Islander may go away feeling abandoned and misunderstood.

At home, Pacific Islanders are accustomed to working through their problems using an established network of chiefs, elders extended family, and friends. The Samoans have a Matai system, an extended clan structure, which will deal with problems arising within the Samoan clan. They also use their religious leaders extensively for any advice or help they may

need. Because of the strong family influence until relatively late in life, the American value of independent thinking may not be developed nor understood, and thus Western-style counseling emphasizing personal decision-making may be inappropriate. It takes a great deal of time to build a feeling of trust, and until this trust is established it may be difficult for the outsider to provide really effective assistance.

The Dilemma of the Asian or Pacific Island Student

In the United States, the foreign student is placed in a real predicament. He is in a situation which may very well engender so much stress that he has difficulty functioning well. The student may not be eating properly or getting any exercise or recreation; he may have sleep disturbances or stomach aches; have difficulties forming friendships with peers or productive relationships within the academic community; and his financial picture may be much worse than anticipated. Yet the student does not have the usual network of friends or family to ask for advice or reassurance.

Since the entire approach to health care among Asian and Pacific students is more holistic than in the West, problems are usually not seen as emotionally or physically based. There are generally no distinctions made between psychogenic, psychosomatic, and other illnesses or symptoms.

Further, the foreign student may have a different way of interpreting events, different means of expression, and different norms of behavior. In many Asian and Pacific cultures, problems are seen as external to the individual. For example, a digestive disturbance for an American might be seen as a reaction to stress, and the individual should therefore reduce the level of stress or "cope" better. For an Asian student, this type of disturbance more likely would be seen as a digestive problem from improper food or eating habits, and can be corrected by medication or herbal aids. However, the student seeking medical advice in the West may be told that his problem is simply due to stress, and his one avenue to assistance is cut off.

Cultural Values

Geert Hofstede (1979), among others, has assessed value systems in 40 countries, seven of which are in the Asian area. (None represents a Pacific Island culture.) The results are characterized in four major categories. Although the specific results are interesting and useful for some purposes, an adviser should avoid generalizations when counseling individuals; the major point in presenting this study is the means of categorization. The four divisions provide ways of thinking about possible differences between American culture and that of the foreign student, as well as

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hints to possible sources of misunderstanding or conflict either inside or outside of the counseling situation.

1. Power distance values: Examples of high values in this area are beliefs based on the concept of power and heirarchical organization as a basic fact of society. People in power should look and behave powerfully; there are innate inequalities which are expressed in society. India, the Philippines and Singapore are all seen as high in power distance.

   Low power distance societies have more of an interdependent organization, with the stress on cooperation rather than power. Any emphasis on power is based on expertise and legitimacy, i.e., power is delegated or earned. The U.S. is low in the power distance factor compared to the Asian cultures studied.

2. Uncertainty avoidance: Examples of high uncertainty avoidance include belief in the need for consensus. Conflict should be avoided becuse it will lead to aggression. There is a value that achievement means security. Strong feelings or nationalism, belief in absolute truths and written rules, and trust in experts are all aspects of high uncertainty avoidance. The Japanese culture is high in this category.

   Low uncertainty avoidance is characterized by the belief that uncertainty is inherent in life and can be accepted. There is more credence placed on common-sense as opposed to rules and experts. Dissent is accepted and conflict and competition are seen as constructive in many instances. Hard work is not virtuous per se and achievement means recognition but not necessarily security. Hong Kong and Singapore are very low in uncertainty avoidance according to this study.

3. Individualism: Examples of high individualism are an orientation to the self as the source of identity; individualistic decision-making; duty based on what is good for the individual. No cultures in the group of Asian countries are high on individualistic values, yet the U.S. is extremely high in this category.

   Low individual orientation is seen in loyalty to the group or clan, which provides a sense of duty, order, and security. There is no real private life; decisions are made by consensus. Different standards are held for the in-group than the out-group; and identity is provided by one's roles

within the social system. Pakistan, Singapore, Hong Kong, and Taiwan are all quite low in individualism.

4. Masculinity: Cultures seen as high in this category have clearly established sex roles, with men seen as assertive and women as nurturing. Men dominate and machismo is an operating ideal. Performance is seen as important, versus the quality of life. Japan and the Philippines are high in masculinity.

   Low masculinity is characterized by less clearly established sex roles, quality of life as more important than achievement, and ambition in itself not seen as a virtue. While no cultures were seen as extemely low in this area, Taiwan and Singapore were found to be lowest of the Asian cultures, and lower than the U.S.

These four categories, may be seen as aids if a break in understanding or communication occurs. For example, the Japanese student who doesn't seem to understand the options presented to her may be expecting an authoritarian decision on the part of the counselor, the person in power in that situation. Or the Pacific Island student may not wish to make a commitment to something without consulting his parents or uncle, although the counselor feels the commitment could be made individually. The counselor comes from a different culture and should be aware of what his cultural values are, so that his judgements of the person are not simply reflections of his own personal style.

The Role of the Foreign Student Adviser (FSA)

When the Asian or Pacific student is faced with the loss of the normal network of trusted friends and relatives, when fellow countrymen or religious leaders in the same setting cannot be counted on to be understanding or trustworthy, and when the problem cannot be defined as a medical one, the student may seek information, advice, and help from school representatives. A student who is guarding his reputation is wary of seeking help from school advisers because he may be unfamiliar with their role or fear they may represent the immigration arm of the institution, with powers of deportation. The student may be more comfortable if the adviser fits into some familiar role model from his own country. For example, a Filipina told a sad tale to the FSA and left feeling that this "friend" gave her a chance to unburden herself. A PRC student advised another troubled student to see the FSA because she was just "like his mother" and not like the typical administrator from their country.

In the area of health, the FSA's counseling should cover those specific topics mentioned in the Orientation section. Further, the student with psychosocial, nutritional, or other

specific problems can be reassured that further counseling or therapy as an integral part of health care. The FSA may also work with a health care provider to assist in difficult decisions regarding medical care. At times, the FSA should also assist medical personnel with academic procedures and enlist the aid of community and cultural resources for the benefit of the student. In all work with students, confidentiality must be maintained and the student must consent to release information to another provider.

NOTES REGARDING COUNSELING

1. The FSA should treat each student as an individual, withholding judgements and assumptions. All the knowledge about differences in culture and cultural values is expressed in general statements with norms or averages. This knowledge helps one to ask the right questions, to have an idea about the student's general background. However, the knowledge can be harmful if it is used to stereotype the foreign student. The student is first an individual with individually or family-based ways of expression and behavior. For example, all students from Taiwan would not want to see an herbalist or dietician when asking for a referral for a stomach ache. It may be helpful for the FSA to keep in mind the categories of values mentioned above in order to ask questions: Does the student tolerate an ambiguous situation; is he used to authoritarian physicians; how important is the student's family and group in decision-making; is she operating according to a traditional sex role which is part of the culture?

2. Approach the student as a whole person, frequently needing a "friend" rather than a "counselor". Remember that most people have some successes, some things they are proud of in their lives in addition to any problems. Frequently addressing these successes will help the student cope with the problem at hand in a much more positive manner. Remember that the way he asks for help and formulates solutions for himself is affected by his expectations of the person he is talking to (Does he see the FSA as a counselor, a mother, a policy enforcer?); by his current overall situation; by his physical condition; and by his past experiences in dealing with the problem.

3. Be active and open. The quiet, (reflective technique) that Westerners typically associate with counseling may be seen as unhelpful. Giving information and suggestions, (making sure that the student sees them as suggestions, not orders) helps the student have more confidence in the FSA. If a problem requires more than one visit, some homework, e.g. list the pros and cons of some possible action, keep a record of how many times such-and-such happens. This not only gives more information to work with in future sessions, it gives the student active

8. When asking intimate details, or details which the student may consider intimate, explain why these questions will help to clarify the problem.

9. Try to assess whether the problem is primarily a current one (e.g. a physical illness, distress resulting from uprooting, a new academic problem, etc.) or whether the difficulty was present before transition to this situation. Zwingmann and Gunn suggest certain factors are "predispositions to disorder". General poor health, extreme dependence on parents, lack of very basic social skills, are all problems which are long term and which may need to be addressed in order for the student to succeed in any adjustment to school in a new culture.

10. Recognize when help is needed. For serious emotional problems (e.g. the student has withdrawn from friends, is overcome by anxiety, is very unrealistic or illogical, is very depressed), for all medical problems, and for specific information or counseling on matters with which the FSA is not completely familiar, referrals should be made. A list of people and organizations, including medical doctors, psychiatrists, social workers, who are experienced with a range of Asian and Pacific cultures, should be accessible to the FSA. Personal communication with these providers can help one to decide whether a referral is necessary, and if a referral is recommended, the adviser can let the student know what to expect.

11. Reschedule a follow-up appointment for a student who has been referred. Unless the situation is resolved immediately, it is important for the FSA to follow-up. This meeting allows the FSA to check on the appropriateness of the referral and to assess whether the student understood the information provided. It also lets the student know that the advisor is an on-going, stable source of assistance, support, and concern when help is needed again.'

INTERCULTURAL ADJUSTMENT PATTERNS

Intercultural adjustment is related to support systems established during critical periods of one's personal development and the supportive network established in one's new environment. Coping with adjustment is a learning process and contributes to the development and maturation of the student. Some individuals may need a supportive network consisting of friends from similar cultural orientations. Other individuals may find challenges and stimulation from intercultural settings and individuals with differing value orientations.

First Phase of Adjustment

Spectator Phase

Adapting and learning skills to cope with new and familiar situations in a different setting.

Affect - Excitement

Areas of Concern

Academic
Housing
Living adjustments
- (roommate
- cleaning
- cooking)

Eating
Caring for self
Mobility (use of transportation system)
Finding new support systems (friends)
Familiarity with the environment

Second Phase of Adjustment - Serious problems arise as one meets situations that are confusing, unfamiliar or needs adjustment from one's previous patterns of behavior. Individuals react differently as they learn to cope with new situations.

Conflict Phase

Somatic Complaints

Loss of appetite
Stomach upset or aches
Unable to sleep
Headaches
Pains in body
Frequent colds or fever

Related Complaints

No friends
Dislikes new culture or environment
Dislikes people - roommates, classmates, teachers
Do not have chances to speak English
Failure from exams (imaginary or real)
Cannot concentrate on studying
Pressure from parents or self

Affective Behavior	Behavioral Manifestation
Homesickness	House cleaning neglected
Anxiety (fear)	Eating improperly
Loneliness	Looking sloppy, sleepy, or messy
High expectations	Goes to Student Health Center often
Low self image	Unable to express feelings
Depression	Not able to study or concentrate
Guilt	Academic failure
Shame	Avoiding people
Self blame	Day dreaming a lot
Sadness	Studying all day but accomplishing little
Withdrawal from school of friends	Very negative outlook
Insecurity	
Feeling crazy	
Anger	

Crisis Situations

Situational - accident, death in family, rape

Maturational - Social relationships

Third Phase of Adjustment

Adjustment

Increased satisfaction comes after getting through the Conflict Phase. One begins to gain confidence and acquires a positive self image. Coping with new situations become an adventure, not a burden. One's educational goal can be realized.

Some Questions to Explore with Students

What did you do for fun this weekend?

Did you have trouble looking for a place to live that you liked?

How do you like your room.... roommates...living alone?

Have you ever been to Ala Moana Shopping Center. What do you think about it. Do you have anything like this in your home country? How often do you go there?

Where do you usually eat? What are some of your favorite foods? Have you tried poi? What do you think of it? Is there some foods that you miss from home?

Do you like the UH? Why did you choose this school? What do you think about the courses you are taking? Are they hard, easy, compared to what you are used to?

What are you learning from your classes & teachers? Are you glad you came here?

Do you like the different kinds of people here? Did you find it easy to make friends? What kinds of friends do you like the best? Do you miss your friends back home? Have you been able to find people here who you can talk and do things with?

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NUTRITION

by Jan Pachelbel, M.P.H.

In addition to a different language and set of customs, foreign students are faced with foods that may look and taste nothing like those they are accustomed to at home. In general, students coming from East and Southeast Asia may find the adjustment process a little less difficult than students from the Pacific because familiar Asian foods often can be found in major supermarkets. However, the student may be faced with various difficulties (lack of money, time, transportation, and kitchen facilities) which prevent him from maintaining a well-balanced diet. Adjustment to new eating habits and lack of proper nutrition are both sources of health problems. In addition, since much of traditional Asian health care is based on consumption of foods which provide balance (of hot and cold, for example), the student may feel he cannot practice basic self-care for common complaints, since the appropriate foods are not available. This section identifies some of the food habits among the major ethnic groups from Asia and the Pacific, and some suggestions in this area for the FSA.

Chinese

Ethnic Chinese students may prefer a style of cooking originating from one of four major regions of Mainland China. Each of these regions is characterized by a distinctive type of diet. 1) The Mandarin style of Northern China uses both pungent sweet and sour dishes and more delicately seasoned foods. Garlic and scallions are used regularly. Steamed breads, dumplings, noodle dishes and barbequed meats are popular. 2) Fresh-water fish and seafood dishes are popular in the coastal region, which includes Shanghai. Thickened sauces, sugar and the dark red soy sauce are common. Rice is the staple food of this area. 3) Szechwan cooking of the third region, inland China, is best known for an unusual pepper seasoning that is used. 4) The southern region of China has a diet commonly termed Cantonese. This cuisine is subtle and the least greasy of all regions. Herbs and a thin soy sauce are regularly used. Mushrooms and nuts are popular in Cantonese recipes. Many varieties of seafoods, as well as pork and poultry are eaten.

Rice is the predominate grain product used by the Chinese. A wide variety of vegetables, mostly cooked, are eaten. The Chinese may have difficulty digesting milk and milk products and may dislike dishes that are creamed or contain cheese. The diet is centered around three meals a day: breakfast, lunch and dinner.

Samoan

Samoans center many of the family activities and ceremonies around eating. Traditionally, Samoans have one very large evening meal a day consisting mainly of fat and carbohydrate with little protein. Samoan foods can be characterized as plain, and if seasoned, the main seasonings consist of coconut milk, onions and salt. Food is prepared in Samoa by either baking, boiling, steaming or broiling. An oven called an umu, which is an above ground sheltered version of the Hawaiian imu, is traditionally used for baking.

Samoans prefer pork over any kind of meat. Salt beef (povi masima) and canned corned beef are other favorites. Chicken is also used; baked or grilled. Raw fish is eaten prepared with chopped onions, salt, and coconut milk, similar to the Hawaiian lomi salmon. Cooked fish is wrapped in ti leaves, seasoned with coconut milk and baked. Octopus, lobster, crab and other shellfish; canned fish such as salmon, mackeral and sardines combined with onions are also popular. Taro is the staple starch of Samoans. Other starches eaten by the Samoans include green breadfruit and bananas, sweet potatoes and bread. Taro leaves, cabbage, celery and onion are the main vegetables eaten by the Samoans. Tropical fruits such as bananas, mangos, pineapple, papayas, and citrus fruit are usually eaten as a snack.

Tongan

Food practices in Tonga vary by island. People on the main island of Tongatapu have adopted Western dietary habits, while Tongans living in more remote areas on the outer islands may still be eating in more traditional ways. Traditionally, food preparation for the entire day begins in the morning. The first meal of the day is eaten about 11 a.m., with a second meal, consisting of leftovers beginning around 5 p.m. Today, food is boiled and roasted as well as baked. Umu cooking is primarily in the preparation of feasts. It is common now for Tongans to eat three meals a day. Every Sunday is considered a holy day when the entire community comes together for the feast. The sharing of food is a very important aspect of Tongan culture, and food is always shared with neighbors and friends. The social ties formed through this custom help form the basis for cohesion in Tongan society.

Sweet potatoes, yams, tapioca, green bananas, coconut, fish and other seafood make up most of the Tongan diet. Meats include canned beef, tin fish and mutton from Australia and New Zealand. Vegetables often include tomatoes, beans, green peppers, and when mixed with meats are often heavily salted. Kava, a fermented root drink, is a very important part of the Tongan culture and is used in ceremonies, for social occasions, and medicinally.

Chamorro

The Chamorros are the indigenous people of the Mariana islands, which includes the U.S. territory of Guam. Food preparation, eating, and the sharing of food are important aspects of Chamorro culture. When friends visit a Chamorro home, it is considered rude not to offer them food. Refusing food when offered is considered an insult.

The traditional Chamorro diet consists of protein sources (fish, chicken, pork, and beef); staples (breadfruit, taro, yam, banana, sweet potato); and fruits (coconut, bananas, papayas, mangos and limes). Spices and salty foods such as soy sauces, pickled food and salted fish are favorites of the Chamorro. The modern Chamorro has a diet of white rice, refined sugar and white flour in place of the indigenous staples, and canned meat and fish. Fresh fruits and vegetables play a limited role.

Korean

Korean food is generally highly seasoned with spices such as red chili pepper, garlic and green onions. A typical family meal for lunch or dinner consists of a soup of meat or fish with vegetables, cooked vegetables, pan broiled fish or meat, rice, and kim chee (highly seasoned pickled vegetables). Breakfast usually includes rice, soup, kim chee and water. Korean meals usually include a wide variety of foods at each meal with all the food placed on the table at one time.

Seafood is an important part of the Korean diet. Salt water and fresh water fish such as carp and salmon are eaten. Shellfish, mollusks and dried seafood are popular also. Soybean products, such as tofu, are another source of protein. White polished rice is the staple starch of the Koreans. Rice gruel (jook) is considered a snack or a bland food to be eaten during illness or convalescence. Koreans use yam noodle vermicelli (long rice) in their cooking in combination with meats and vegetables or in soups. Vegetables are a large part of the Korean diet. They are usually cooked for only a short time so that they retain their crunchiness. Kim chee is a staple in the Korean diet. It is made out of cabbage, Chinese cabbage, turnips or cucumber which is soaked in a mixture of salt, garlic, ginger, chives, and chili pepper. Fresh vegetables in the Korean diet are usually served as a salad called namul. Spinach, bean sprouts, watercress, cabbage and cucumbers are frequently prepared this way. Other vegetables eaten by the Koreans include zucchini, lotus root, eggplant and peppers. Fruits are usually eaten at the end of an everyday meal as dessert.

Thai

The Chinese have a strong influence on the dietary patterns of Thai people. A typical meal in Thailand consists of stir-fried vegetables with small pieces of pork or chicken, crisp fried noodle dishes, and fish seasoned with ginger and soy sauce. In addition to stir-frying, simmering, barbecuing and steaming are all cooking methods commonly used in Thailand. Seasonings include curry, fish sauce, lemon grass, galingale (a rhizome of the ginger family), fresh mint, Chinese parsley, chili peppers, garlic and shallots. Thais have a basic hot sauce (nam prik)that appears at every meal that is a dipping sauce for all foods.

Thais are mostly fish eating people. Freshwater and salt water fish, shrimp, prawns, crab, lobster, squid, and oysters. Meat and poultry are served at special occasions. Rice is the staple in the Thai diet, and most Thais eat long grain rice with every meal. People in the Northern Thailand eat a short grained sticky rice. Noodles made from either eggs, rice, mung beans or rice vermicelli are all eaten. Vegetables are a major part of the Thai diet and are served at every meal. Salads of raw vegetables as well as stir-fried vegetable dishes are popular.

Vietnamese

Vietnamese food is similar to Thai food, but it is not as highly seasoned. Like Thai food it is highly influenced by the Chinese. The Vietnamese eat white long grain rice, and do not mix the rice with other foods. They are the only people in Southeast Asia who eat with chopsticks. Vietnamese food has a more subtle flavor than Chinese food. French bread, croissants, cheese and coffee are enjoyed by the Vietnamese because of the French influence on their culture. The traditional Vietnamese diet consists of rice and vegetables supplemented by small amounts of fish, or less often duck, pork, beef, or chicken. Salty pungent fish or shrimp sauce is a popular condiment. Milk is not part of the diet for adults. Vietnamese meal patterns consists of breakfast, lunch, dinner and snacks. A typical breakfast in the cities consists of french bread with margarine and sugar and a cup of coffee with condensed milk. Other breakfast foods are: steamed mochi rice with ming or azuki beans, fish with fish sauce and pickles. Lunch and dinner usually include rice, vegetable soup made with pork or fish, and a pork or fish main dish, stir-fried vegetables, fruit and tea.

Laotian

The Laotians prefer sticky rice rather than conventional white fluffy (long grain) rice. The rice is traditionally eaten with the fingers and dipped in soups and stews.

Laotians do not use chopsticks or other eating utensils, depending mainly on fingers and sticky rice to get food into their mouths. Meals are eaten family style with food placed in serving bowls and rice in colorful baskets. Sticky rice with a boiled egg or roasted meat or fish are typically eaten for breakfast. Lunch and dinner consist of rice with highly spiced stews of meat or fish and vegetables. Laotians use a fish sauce called nam-pa, fermented fish or padek, chili pepper, lemon grass, dill, limes and tamarind to season their foods.

Fish and seafood, pork, beef, chicken, duck, and buffalo are protein sources in the Laotian diet. Vegetables include mustard cabbage, chard, cucumber, lettuce, tomatoes, mint leaves, bean sprouts, green beans, egg plant, cowpeas and green papaya. Fruits are usually eaten as a snack. Laotian favorites are papaya, jackfruit, mango, banana, tamarind, and tangerine.

The Role of the Foreign Student Adviser

Since food may be a less sensitive topic of discussion than sexuality or academics, it may be less difficult for the FSA to encourage the student to discuss questions such as "Are you able to find the foods you are use to?" This can lead into a discussion which will enable the adviser to determine whether there are problems in this area or others.

Students may need to know where they can purchase foods similar to those at home. The FSA can make a brief list of markets in their area that stock Asian and Pacific foods. Listed below are a few locations in Hawaii for purchasing some of the foods and seasonings used by Asian and Pacific Island students.

Open Market on King and Kekaulike Streets: Open Daily
(Hawaii's Chinatown)

People's Open Market in the parking lot of the McCully Recreation Center, 831 Pumehana Street at McCully:
Open Wednesdays 8:15 - 9:15 a.m.

Asian Market on Beretania at King Street: Open Daily

Star Market on King and Hausten Streets, and other local supermarkets: Open Daily.

Limited economic resources may be a problem for foreign students, especially where the cost of living is very high. Students may not have the knowledge or skill to eat properly on a minimal income, or their income may simply be completely inadequate. The FSA should be aware of any programs which assist students in obtaining adequate food. Students from Micronesia and Samoa may be eligible for food stamp programs and they can use this to help improve the nutritional quality of the diet for themselves and their families. Most foreign students are eligible for the Special Supplemental Feeding

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Program for Women, Infants and Children (WIN). This is a special food program for pregnant and breastfeeding women, their infants, and children, who have a nutritional difficulty and meet income criteria. Students can be encouraged to check ads for sales. Planning meals based on less costly foods can help to make the food bill more manageable.

Foreign students with concerns related to their diet or nutritional status can be referred to a nutritionist familiar with Asian and Pacific diets, who can advise students on locations of ethnic food stores, appropriate substitutes for difficult-to-obtain items, how to cope with dormitory food, how to assess various published diets.

SEXUALITY AND SEXUAL HARASSMENT

by Nancy Stockert, M.S.W.

Relationships With the Opposite Sex

One of the most difficult aspects of the foreign student's adjustment to United States culture is that of building relationships, especially with the opposite sex. For some, individual dating practices are unheard of. For many, premarital sex is unthinkable or at least shameful. Even discussion of sexuality and display of any sexual feeling is not permissible. Family planning is something for married couples literally "planning families". Even for those who come from major urban centers, especially Tokyo, in which attitudes among young people are much more permissive, discussion of sexuality is secretive and only among peers.

For students from Asia and the Pacific, expectations regarding sexuality in the U.S. are based on movies, T.V., and magazines such as Playboy. Thus students anticipate general promiscuity, or at least universal acceptance of openness regarding sexuality. It is difficult for students to approach anyone regarding their anxieties about appropriate behavior in this society. Distorted expectations are therefore not corrected, and the student may react in one of several ways. Some students merely withdraw from opposite-sex relationships except with those of their own culture. Others become inappropriately assertive, thinking that this is the norm. Still others "go along" with behaviors which are considered to be wrong in their own society, but which they feel are necessary for them to be accepted in the U.S. As a result, a shy woman from Taiwan may find she is having a sexual relationship with someone with whom she is barely acquainted because she did not know how to say "no" in a forthright manner. Or an Indian man finds that women are hostile, but he does not realize that he is being inappropriately assertive. Or a Japanese student becomes pregnant because she was too embarassed to ask anyone to refer for her birth control information.

The consequences of lack of or incorrect information can be disastrous. Not only do many students feel anxious about even casual encounters with those of the opposite sex, they may be rejected or find that they have compromised their own moral code. Worse, they may suffer what they feel is sexual harrassment because they misinterpret others, or may tolerate what(in this culture) is obvious harrassment or even abuse because they do not know what is considered proper behavior. They may become pregnant or may find that their "true love" did not intend a serious relationship. The consequences thus may range from strain and loneliness to medical and emotional crises.

The Role of the Foreign Student Adviser

The FSA can orient foreign students as to the variety of customs in the United States, clarifying that all people in this culture are not as open to physical intimacy as the movies portray, and giving each student permission to maintain his own value system and to explain that value system to others. As mentioned, the best procedure may be to have fellow students discuss their own experiences. By providing information on appropriate places to meet others, expectations on a first date, options regarding group dating, and other interactional information, the FSA may be able to help students avoid some of the anxiety and loneliness involved with living in a new culture. Skill-building, such as practice in conversing with a person of the opposite sex, also may be helpful.

Second, the FSA can provide programs by those in the community who are knowledgeable about reproduction and sexuality. Many foreign students may not even have basic information about their own bodies, and this information can be presented in a sensitive way by someone who is aware of the students' backgrounds and anxieties. Creation and distribution of written materials designed for foreign students may be extremely helpful for those who may have questions which they would be too embarassed to ask in a group. As part of a general health program, a section might be devoted to family planning, providing information about birth control methods which are available, clinical facilities and processes, and cost of services.

The FSA can become knowledgeable about facilities which give information on contraception and provide examinations in a manner which is least intrusive and abrupt. (For women students a female practitioner may be preferable to a male in many cultures.) The provider should also be experienced at talking with a male partner who may see it as his role to find out about birth control for his wife or girlfriend. If finances are a concern, many clinics operate with a sliding fee scale which provides for low-cost or free services to those who are on minimal budgets.

In publicly funded family planning clinics, the female student will probably go through the following process:

1. The student will be asked to complete forms asking for demographic information as well as information about medical and sexual history. The information is confidential and is obtained so that the clinic can assess what method of birth control will be safe for the student, as well as to help the student decide on a method best suited for her.

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2. She may see a counselor to help her assess the options, choose method and discuss any related concerns.

3. Urine and blood tests will be done.

4. A pelvic examination is usually the most anxiety-producing part of the visit, and most clinics have someone explain how the exam is to be done and why. Women who have not been sexually active yet may be concerned about a pelvic exam causing loss of virginity. Frequently their fears can be allayed by discussing the procedure and by the use of smaller instruments.

5. Use of the chosen birth control method will be explained and written materials on that method will be provided. A follow-up visit will sometimes be scheduled or the student will be given a reminder note about when to make the next visit.

A student will not generally come to the FSA for sexual health needs. However, it is often difficult for students to discuss these needs with those of their own culture because they feel they will be inappropriately judged. Therefore the best approach for the FSA is to offer information in written form so the student will have it if necessary. When a student does approach a FSA with questions about sexual health, the advisor can assist by explaining the procedures generally followed, referring to a specific clinic or physician known to be experienced with students, and, as with other medical care, making it clear that the provider will offer options and information rather than telling the student what to do.

Many students are not sexually active. However, it is important for them to have some information about genital problems and their treatment. They should be aware that when they seek treatment, questions may be asked about sexual activity and that the clinician is asking not to pass judgement but to ascertain the nature of the problem. Again, the FSA should be aware of and refer to those clinicians who are most sensitive to the needs of foreign students.

Sexual Harassment

Sexual harassment includes, but is not limited to, the following, as defined in the University of Hawaii Policy on Sexual Harassment:

1. Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

2. Solicitation of sexual activity or other sex-related behavior by promise of rewards and/or threats of punishment.

3. Activities of a sexual nature which have the effect of unreasonably interfering with an individual's performance or creating an intimidating, hostile, or offensive environment.

4. Verbal of physical conduct of a sexual nature, expressed or implied, imposed on the basis of sex, that denies, limits, or conditions the provision of aid, benefits, services, or treatment.

In a university environment, sexual harassment often means that an authority figure (such as a teacher) is making sexual approaches toward a student. Whether or not the teacher implies that a different grade will result depending on the student's response, the student is put in a very uncomfortable position, finding it difficult to give a straightforward "no" to someone who is in an authoritarian position. For the foreign student this scenario becomes exaggerated.

First, for an Asian student in particular, the teacher is a true authority figure to whom one must show proper deference. Second, improper sexual innuendos may be seen as something that is done routinely in the United States; i.e. the student may feel that her feelings of discomfort are inappropriate. Third, the student may feel that she has done something which has caused this behavior and thus may blame herself. And finally, even if the student feels the behavior was wrong, it would be extremely difficult to say "no" to an authority figure under the circumstances. In addition, the foreign student may be too embarassed to discuss the harassment with anyone and may thus let the situation continue until it reaches crisis proportions.

The FSA, again, is not usually contacted and thus can offer preventive information only. By providing information and examples at orientation regarding what is normal and what is not expected in this society the FSA can assist the student in assessing the situation. For example, a teacher who has a beer with several students is not being forward, but rather friendly and open, and the student should feel to either say yes or no to this kind of encounter. On the other hand, open flirtation with a student is considered improper, and the student should be encouraged to discuss it with the FSA if confrontation with the person is not possible. Letting the student know that this situation arises with many students (it is not their fault), that it is not accepted (there is a policy regarding sexual harassment), and that there are techniques which work and may help the student sort out feelings and decide what action to take. Techniques include

learning to say no in a definite way and writing a clear letter to the person, stating what behavior is causing difficulty, why it is uncomfortable and that it must be stopped or further action will be taken.

Of course, there are sexual harassment situations in which it is not an authority figure but rather a peer who is causing discomfort. Not infrequently, a male foreign student is dismayed by the aggressiveness of a female from this culture who either misinterprets or takes advantage of his politeness and lack of knowledge of sexual norms. Again, the FSA will almost never learn of such situations until after the fact. The best approach is to be the preventive one; or reassuring the student that his own code of conduct in regard to sexuality does not have to change in order for him to develop relationships in this country. The FSA can also assist the student in developing clear statements of unwillingness to participate in sexual or intimate relationships.

The FSA must be a sensitive person with a "third ear", open to hints of problems regading sexuality. Someone's dislike of a teacher may be based on the teacher's inappropriate advances; someone's unwillingness to go out with that "nice guy" may be the result of ambiguity regarding what is expected. Gentle investigation of hints may help the student to resolve a problem before it expands into a crisis.

ACADEMIC PROBLEMS

by June C. Naughton, M.Ed., M.A.

There are two reasons for including a discussion of academic problems in a handbook on health care for foreign students. First, because many students from Asia tend to somatize stress, academic concerns frequently lead to health problems. Second, any health problem may have an effect on academic success.

Students on a college campus have many reasons for pursuing a higher degree, regardless of ethnic origin. However, American students have a variety of alternatives if they choose not to continue their academic program or if they are academically suspended. They can work temporarily at a job nearby or take a vacation. While they may encounter their family's disappointment or concern, the option of higher education at a later time continues to be open to them. In contrast, foreign students are expected to enroll in a full course of studies and make adequate progress toward a specific educational objective according to immigration regulations. If foreign students are not able to do this, they are generally expected to return to their home country.

Asian Students

The Asian culture places a very high value on education as a means to a better job, higher status, and especially for the ethnic Chinese, honor for the family. Low grades and especially outright academic failure mean shame and consequently low self-esteem. The fear of returning home because of failure in studies means that the student will not be able to contribute to the pride of the family and may be a financial burden forever. Assurances that an academic suspension is temporary will not necesarily change the fear and sometimes the reality that there may be no further opportunities to return to the United States for studies.

Problems may vary depending upon the country or culture of origin. Some Asian students feel pressure to maintain a high grade point average in order to be eligible for graduate school and possible options for permanent resident status. While undergraduate Hong Kong and Singapore students seem to compete for grades, many Japanese undergraduates are not so pressured to maintain such a high academic standard. Once admitted, the Japanese student usually expects to be able to graduate barring financial or personal reasons, which is generally true of schools in Japan. Thus suspensions and failures may come as a surprise, especially when academic requirements and grading criteria are not clear.

Selecting an appropriate major is a difficult problem for the Japanese woman undergraduate who may be deviating from the traditional expectations of women in Japan. These women feel their career choices are limited if they return to Japan and therefore may feel pressured to take "practical" courses they may not be interested in studying.

It is important to distinguish between graduate and undergraduate expectations. Graduates may have a greater sense of purpose in studying abroad, may be older than the average American student, may have held positions of responsibility in their home countries, may be married with children, and may be holding some scholarship or grant. Their pressures are great due to the expectations of their culture, but because of their age and status they may have a more difficult time in adjusting, especially if their language is weak and their experiences outside their own culture are limited. The Asian assumption that the professor will give firm academic direction may cause misunderstandings and even crisis, especially when the student feels unable to ask specificlly and directly for help with academic problems or plans.

When academic problems cannot be resolved somatic complaints may result. The pressure from academic difficulties may cause insomnia, the inability to concentrate, and loss of appetite. When Asian students feel the solution to their problems is to spend more time studying, often inefficiently or ineffectively, these problems may escalate to crisis proportions. Failure is so unacceptable that the student may entertain suicidal thoughts rather than returning home in shame.

Pacific Island Studies

In comparison with Asian cultures, formal education is a relatively new tradition for the Pacific Islander. An academic degree means prestige, status, and probable government employment back home, especially in Micronesia. Unfortunately, the discipline of study often gives way to the cultural value of maintaining harmony in social relationships. The expectations of the peer group take precedence over the individual's desire to spend time studying. Micronesians may have a weak science and math background, and may not have acquired adequate study techniques. Young Micronesian students who fail may prefer to remain in the United States hoping that they can find some way of succeeding before returning home.

As with the Asian student, graduate students from the Pacific are under more pressure and have difficulty adjusting to the role of a student, particularly if they have come from positions of prestige and responsibility.

The Role of the Foreign Student Adviser

1. The FSA should be aware of the fact that somatic complaints may be the expression of stress resulting from academic pressures. While the FSA should refer the student for help with his physical symptoms, she should also listen for hints of difficulties with school.

2. Academic faculty (especially ESL teachers) can be advised to alert the FSA when students are absent for an unusual period or seem to be particularly troubled. In turn, the FSA can be an advocate for the foreign student who has difficulty discussing academic problems with the teacher. The FSA can help the student rehearse what he will say, or make direct contact with the teacher if there is a major problem with communication.

3. When the student's English is weak, the FSA can suggest lower level courses, math courses (especially for Asian students good in math), or other courses not demanding complex reading/writing assignments. If English needs a great deal of improvement, the FSA can refer the student for tutorial programs. Pacific Island students especially may benefit from the one-to-one interaction of tutoring or from small classes where they can receive support from the teacher and the other students. Math and Science courses are more difficult for the Pacific Islander unfamiliar with the Western logical process.

4. The FSA can help the academically weaker students understand the wise use of the Credit/No Credit option.

5. Immigration regulations allow students to drop below full-time status for medical or psychological reasons. A physician's note in the file will provide adequate justification for a reduced course load. This option may be pursued not only if the student is physically ill, but also if the course load is so overwhelming that the student is in danger of failing to the point of being suspended.

6. An on-going orientation program can address some of the above issues. In addition, graduate students should have an opportunity to discuss the differences between U.S. and home country educational practices with other graduate students.

V.

Crisis Information

A CRISIS INTERVENTION MODEL

(The following sections are authored by June C. Naughton)

The crisis intervention technique may be the preferred mode of the adviser working with Asian and Pacific students. These students seek concrete solutions to their problems. The active, direct, and supportive role of the crisis adviser is appropriate as the Asian students often prefer to focus on the resolution of the immediate problem, not on why or how it might have occurred. The aim of the crisis adviser then is to help the student be in control of his life again. The adviser therefore should help the student make difficult decisions for action, gain an intellectual understanding and control of the problem, release feelings of anxiety, guilt, anger, shame, etc., and anticipate planning to resolve and control future problems (Auilers, 1978). If, however, the crisis is acute, the adviser may need to take temporary control to help the student find the necessary resources to resolve the crisis situation quickly.

Steps in Crisis Intervention

1. The Initial Contact. Even when the Asian student is distressed, he may begin with some polite words of greeting, to show respect for the teacher as expected in most Asian cultures. He will also look for familiar non-verbal signs and words, especially those of a teacher and/or advocate which indicate care and concern. These preliminary gestures establish the necessary relationship which allows the student to be open to the adviser.

2. Clarifying the Initial Problem. Identifying the real problem may be more difficult with Asian and Pacific students who may be unfamiliar with enough English to express clearly the basic problem or the emotional crisis. Therefore it is important for the adviser to listen carefully and restate the problem while trying to assess the feelings of the student accurately.

3. Learning What Happened. The adviser learns from the student the precipitating event that brings the student to seek help at this particular time. This event usually occurs within 1-2 weeks before the student seeks help or may even have occurred within the past 24 hours. The adviser may ask if the student has had any previous experiences with this problem and what was done then to alleviate the problem. The adviser also learns what current resources the student has or can call upon for help. This will help the adviser assess the extent of the crisis.

4. Intervention Strategies. If the student has suggestions for the solution to the problem then the adviser can supplement this list based on other resources and experiences. The adviser is careful to support the efforts of the student to relieve the problem. When necessary, the adviser should consult with other institutional or community resources to find additional ways and means of resolving the problem and to obtain the most current and reliable information for the student.

5. When the Student Cannot Cope. If the crisis is serious and the student is unable to maintain control over the situation, the adviser may have to assume a more direct and active role. The adviser may need to decide who the student needs to see, such as a medical doctor, a psychiatrist, a lawyer, the police, and take responsibility in making sure that the student seeks the most appropriate help for the problem. Consultation with parents may be necessary as Asian and Pacific parental control extends beyond American norms.

6. Follow-up. Be sure to set a follow-up appointment to insure that the solutions helped the student effectively especially in time of crisis. This interest gives the student permission to return prior to a crisis when other problems occur.

Notes to the FSA on Crisis Intervention

The Asian student, especially the student from Hong Kong, Taiwan and Singapore, who has more experience with higher education institutions may have already exhausted other services for help. The Southeast Asian student may not directly state his problems or wishes. Telling the adviser about a direct need may be construed as rude and presumptious. Therefore subtle hints are often used with the assumption that if the FSA is willing, he will help. The adviser must then try to state the problem being hinted at. Some South Asian students may seem very direct with their requests and sometimes seem almost overtly aggressive. A clear explanation of how decisions are made may save much time and energy and get at the issues or crisis.

Pacific Island students, with few experiences of specialized services and large campus facilities, may not know where to go to find the appropriate services to help them. They may also be afraid to approach others with whom they have not developed a relationship. Newer students may need to be "guided" by other Pacific students or the FSA.

The Pacific student may remain silently respectful, going along with all suggestions, verbalizing what they think the adviser expects them to say. They often lack the confidence and assertiveness to follow through and are afraid to admit this to the adviser.

PHYSICAL VIOLENCE (PHYSICAL ASSAULTS, SEXUAL ASSAULTS, ACCIDENTS)

For any emergencies in the United States, especially those that involve physical injury, the number 911 can be dialed as the emergency telephone number in most urban areas. The operator who answers will listen to the situation and connect the caller with the appropriate agency which will reply to the problem. Generally, a policeman will respond in a short time to assist in any way possible and get objective and accurate information for a report. Should there be any need for the police report, this is available at a later time.

Physical Assaults

Victims of physical violence in most Asian countries also have access to emergency numbers for the police when necessary. However, students interviewed at the UH indicate that they would be reluctant to call the police in these instances, preferring to first consult their families or friends to obtain advice about calling the police. Students from Singapore, Thailand, Korea, and the Philippines report that they have little respect for the police in their countries and that more than likely no action will be taken by them. Some of the students fear the police record would be open to the community and their family name might be damaged before any aggressor would be found. Students from Japan seem to be more willing to seek police assistance, while the Micronesian students indicated they would call the police only if the aggressor was not know to them. In general, students said they would most likely seek medical care on their own if physically injured in an assault rather than call the police.

Notes to the FSA on Physical Assaults

On a large campus like the University of Hawaii, the FSA would not generally be informed of an assault unless some financial, academic, or immigration problem is related to the physical violence, or the situation is so complex that the student needs experienced help. Most foreign students would feel that the problem was their own and would try to resolve it in their own culturally appropriate way when at all possible. When there is a opportunity or need, the FSA may explain the role of the police in the United States. Letting the students know what is appropriate and not appropriate to say to the police is important because of the different assumptions of the role of police in each culture.

Sexual Assaults

Asian women are not accustomed to the dating modes in the U.S. They may also not know how to say "no" directly and definitely. This can lead to many misinterpretations and difficult situations. Even now, American women are reporting more and more instances of date rape which the Asian student would find most traumatic and self condeming. Asian women interviewed have indicated they would not report a rape because of the feelings of shame and guilt associated with this act. One East Asian women said that she would "keep the hurt in her heart" and try her best to go on with her life. Another said that if it was so bad, committing suicide would be a possible alternative so as not to bring shame to her parents. The FSA must work very sensitively with Asian students who have experienced rape. It is unlikely the student would be willing to visit a Sex Abuse Treatment Center, but the FSA can call for the student to get needed advice to help the student through this period.

A Pacific Island woman is very vulnerable to sexual or physical abuse from men of her own culture. Many Micronesian cultures still have strong sex role expectations which place a woman in a weaker position. A woman so abused would not think of reporting this problem to the police but protection may be necessary temporarily.

Not much is written about spouse abuse among Asian and Pacific students, but this is an area of concern for the Foreign Student Adviser.

Notes to the FSA on Sexual Assaults

International Student Offices can make available clear guidelines and protective suggestions for students to help them be more aware of the problems of sexual assault and harassment. Grievance procedures should also be openly publicized to give concrete information about the rights of women (and men) in these instances. Publicizing the work of the Sex Abuse Treatment Center may give some students the knowledge that others have similar experiences and they can get help. A new booklet about sexual assault in Hawaii containing information about preventing attacks and medical/legal procedures has been published by the Honolulu County Committee on the Status of Women. Single copies can be obtained free from the Office of Human Resources, 650 South King Street, Honolulu, Hawaii, 96813.
(See Previous Section on Sexuality...)

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ACCIDENTS INVOLVING MOTOR VEHICLES

While automobile insurance is required in most Asian countries, individuals involved in accidents may be accustomed to resolving their damages informally and calling the police only when serious injury or a non-resolvable situation has occurred. In rural areas police may not be available and injuries are often taken care of by the families of the one who caused the injury. Automobile insurance may be ineffective in such cases.

Foreign students often do not kow the regulations and the necessity of automobile insurance. They are sometimes subject to harassment and abuse by people taking advantage of their inexperience. They may also not know how to make claims in case of injuries or damage. In cases of very serious accidents in the U.S. the foreign student adviser may be called to assist and respond to injuries or other problems arising from the accident. The FSA can provide important services to the student and medical personnel to take care of such problems especially when injuries occur.

Notes to the FSA on Accidents

The student may need help to clarify the details of the accident to avoid miscommunication between parties, police and insurance agents.

The student may want help with informing his parents in cases of serious injury.

It may be wise to recommend a lawyer if the situation seems to require it.

The FSA can give advice about and help with missed classes, exams, partial or total withdrawals, and other immigration worries that may arise as a result of injuries or stress from the accident.

SERIOUS ILLNESS AND HOSPITALIZATION

Most American students are accustomed to the concept of Western scientific medical practices and medical services which are usually partially paid for by some form of private health insurance. In a few cases, these students may also be eligible to have a portion of their medical expenses paid with state and federal assistance. In contrast, foreign students will have assumptions about Western medical practices from their own culture, but they may not know the extent of the many specialized medical services and diagnostic tests expected when serious illness occurs with the attendant costs.

While these problems may be complex in themselves, the additional concerns from a serious diagnosis, family considerations, fear of hospitalization, and the effect of the illness on the students' academic status may affect the Asian and Pacific students in a special way.

The Illnesses

Confronted with a possible serious diagnosis, language and cultural barriers may interfere with effective discussion of the illness and related problems with a physician accustomed only to Western medical practices. The student may not understand completely the physician's explanation of the illness and the prognosis. The doctor may misunderstand the student's explanations of the symptoms, physical problems, or even the cultural values of the student which relate to the illness. The student may give the doctor total control to handle the problem because of the assumptions that the "doctor knows best" or terminate the visits to the doctor despite the nature of the illness because of the belief in fate or because of misunderstandings that occur with the attending physician. The student also may prefer to seek more familiar and traditional remedies for the illness before deciding on surgery or continued medication. They may encounter conflicts with the Western oriented doctor who does not believe in the effectiveness of these remedies. If the illness is serious, the student is left with the question of the effect on his life.

If the adviser learns about the health problem of a foreign student, he may need to assist in the communication between doctor and patient. Perhaps the adviser can help the student obtain a second or third opinion especially from a doctor who speaks the same language and can explain the illness in terms more familiar to the student. The FSA should identify resource individuals with information about health care for Asian and the Pacific student to assist the student in making the best medical decisions.

Family Concerns

An Asian student may be reluctant to inform his parents about the nature of the illness to prevent them from excessive worries. Yet he may still need an older person to give advice and moral support at this time. The FSA may be this older person. Perhaps the FSA may decide that the student should advise the family. Consultation with them about further treatment, especially if the illness is serious, is necessary because of the nature of Asian and Pacific families. There is the chance that the family may want the student to come home for further diagnosis and treatment while the student would want to remain and complete his studies. The adviser can help the student look at the problem realistically, taking into consideration the perspectives of both the parents and the student. The adviser should also take care to respect the wishes of the parents, although most parents would appreciate the advice of the foreign student adviser at this critical time.

Fear of Hospitalization

Asian and Pacific experiences with hospitals are not pleasant. In some cases, hospitals are places where one goes to prepare for death and it is natural for students to be fearful. American hospitals with specific visiting hours and quiet times do not fit an Asian or Pacific concept of a place for the sick or dying. Family members and friends back home may be accustomed to congregate at the hospital to cheer the patient and provide food and support. Without his family and close friends, the student may be lonely and frightened. The FSA should be sure to visit the student if at all possible and encourage others to drop by at the hospital.

Financial Concerns

An Asian or Pacific student may assume that health insurance will pay for all medical expenses and may not understand the cost-sharing aspects of the policy. The FSA may need to explain the concept of health insurance in the U.S. and which expenses the insurance will cover. Furthermore, when the services of the attending physician, specialized services and diagnostic tests require partial payment (as is true with most private health insurance policies) the student may not have sufficient financial resources to pay the medical bills.

Effect on Academic Studies

The Asian student will be concerned that his academic studies will be affected especially if the surgery, illness and recovery period will be long. He would be worried about his future life, the delay in graduation which may involve additional expenses for the family, and his immigration status. The FSA can alert teachers about the student's

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illness or hospitalization and get some advice as to whether he can continue or should withdraw from classes. Discussion on these issues and assurance that the recovery period would not jeopardize the immigration status would greatly help the student.

Notes to the FSA on Serious Illness and Hospitilization

Some students confuse life insurance with health insurance.

Bills from the hospital, doctor, or diagnostic services can cause stress for the student already troubled by the illness. The FSA might be able to make arrangements for delayed payments and/or look for possible support from the academic and community resources to help with medical expenses.

Immigration regulations often worry the student and the FSA should assure the student that recovery is the first priority.

The FSA can also provide valuable information about resuming studies when the student has recovered. This element of anticipation can be very helpful in making better decisions for the student.

MENTAL ILLNESS

When students can no longer cope with academic and life processes they can suffer severe emotional problems that may require reduction of their academic load, total withdrawal from school, possible hospitalization and/or their return home. These emotional problems may come from the stress of living abroad. The pressures of living and studying abroad increase the tendency for emotional breakdowns especially for those who have had mental problems prior to their program abroad.

Some signs of severe mental stress especially found among Asian and Pacific students outlined by a University psychiatrist are:

"Spaced out" or flat emotions
Low energy, slow motions
Loss of appetite
Chronic insomnia or lack of sleep
Inability to concentrate
Suspiciousness of other people
Hyperactivity with rapid statements that may be incoherent.

The Asian student generally is more controlled even in an emotional crisis than a typical American student. Therefore, it may be more difficult to determine the extent of the problem and how long the problem has been affecting the student. The FSA should try to learn quickly what event recently occurred to precipitate the crisis and to seek a quick resolution of the immediate problem while working on the more complex mental state.

Certain Asian students in desperate circumstances may have been contemplating suicide for a long period. If suicide is suspected, the questions outlined in the Suicide section should be sought if the student or others might be in imminent danger.

A student may have symptoms that are culturally based. A Taiwan psychiatrist who has written extensively on students from that area feels that unresolved conflicts with dominant parents, along with their high academic expectations, make an individual potentially weak and unable to cope with independent living (Yeh, 1969). He further speculates that paranoid symptoms are common among students from non-Western developing countries. Dr. Yeh feels that paranoid patterns of behavior may be easily regarded as average or non-psychotic in students from Taiwan because of that country's social and political reality and can easily escalate when the fear of failure is imminent. Persecutory delusions may extend to school personnel, immigration

officers and security personnel. He suggests that a therapist from that culture could best treat the student and that the student should be sent home if no relief is seen.

In the Pacific Island culture of Samoa an abnormal mental condition is described as someone walking around without a purpose at strange times, talking without meaning, behaving in a bizarre manner. In times of excessive worry or depression, the primary source of help for a Pacific Islander is friends, relatives, pastors, or even the hospital. Individuals may try to wait until the problem disappears or they may be isolated temporarily.

Referring the Student to a Doctor

A student in severe emotional crisis may be willing to see a medical doctor to restore his physical well being, such as restoring normal sleeping or eating habits, but may be unwilling to see a psychiatrist which denotes mental illness. The medical doctor or psychiatrist may be able to help the student regain his emotional balance by the use of medication while the psychologist would use more verbal or behavioral means to help the student resolve the problem. The student may develop a trust relationship with the FSA, and in this instance the FSA may need to take responsibility almost as a surrogate parent to be sure that the student finds the necessary help.

Accompanying the student to see the mental health care provider is essential when the breakdown is severe. This assures the FSA that the student is getting professional help and will assure the student that someone cares enought to be with him at this confusing time. Assisting the doctor and student to overcome academically related problems are part of this crisis intervention assistance.

With many Pacific Islanders, referral to other individuals familiar with the student's culture may be more appropriate. A supportive network of friends may give the student confidence and acceptance. The church influence in the Pacific Islands is strong and many ministers are recognized as healers, contributing to the physical, mental and spiritual welfare of an individual.

Notes to the FSA

Medical doctors may be familiar enough with academic procedures to assist the student adequately. Continued contact with the student during this period is necessary to help the student regain confidence to return to his academic program.

A student may need to be accompanied home if the emotional problem is very severe. Calls to parents for airfare, and

finding funds for a second airfare if the parents cannot come may be a big problem.

The student whose problem is with the family may not want to return home and may disappear. It is important therefore to keep the relationship supportive to encourage the student to return to seek help when needed.

There are "crisis" houses to take severely disabled individuals temporarily. This will help when the students are recovering from hospitalization or is no longer welcome in their own apartment. Call the Suicide and Crisis Center number for referrals.

As mentioned, an important source of help is from fellow students or the student's own religious group. They can offer supportive contact with the student during this critical period.

SUICIDE AND ATTEMPTED SUICIDE

Suicide is "an individual's maladaptive choice of action aimed toward correction/alleviation of what is perceived as an intolerable existence" according to the handbook, "Suicide Theory" (1976). It is important then to remember that suicide, or attempted suicide, is the individual's solution to the problem, not the problem itself. While many people may assume that an individual who is suicidal is mentally ill, studies have shown that while the person may be extremely unhappy, the individual may not be necessarily mentally ill. A person willing to talk about suicide, may be undecided about living or dying and may be asking for help (Schneidman, 1961). Adolescent suicides in the United States are becoming epidemic and among the third leading cause for death among 15-24 years of age. Suicides, both attempted and completed, among young people below the age of 30 in Asia and the Pacific are also very high and reaching epidemic proportions according the Headley (1983) and Hezel (1985).

Causes

Interpersonal problems with family, including marital friction, child-parent disagreements, extended family disputes, and in-law troubles were some of the primary causes for suicidal acts in Asia according to Headley's study. In many Asian societies, family and societal expectations take precedence over the individual's desire. This necessity to conform without known acceptable alternatives may make an individual desperate to the point of choosing death.

Failures in love were listed by Headley as the second major cause for suicides in Asia. This directly affects the Asian student in the United States because of the differences in marital and sexual values between the Asian and American. For example, an Indian student distraught by his American girlfriend's threat of leaving him killed himself by taking poison on the UH campus. Many more attempted suicides or threats of suicide go unreported when relationships fail and an individual is unable to cope with the feelings of hurt, humiliation, and failure.

Failures in examinations, as possible causes for suicidal behavior in Japan and India, may be linked to problems with family expectations (Headley). Asian students studying abroad may be depressed that they have spent their family's funds and yet failed. They may feel the shame of failure, fear the criticism of the family and relatives, and be ashamed of the increased burden because they no longer feel employable.

In the Pacific Islands, traditional values clashing with Western ideas are causing a breakdown of respect for elders and family authority (Hezel). This factor and an increase in alcohol consumption are linked to the great increase in suicide rates among the Samoans and Micronesians. Anger toward parental control of decisions may cause a young Micronesian to hang himself in an impulsive retaliatory manner.

Religious Beliefs

According to Dr. Lee Headley in her book Suicide in Asia and the Near East, the common religious beliefs in Asia teach that suicide is wrong. Thai Buddhism regards a person who commits suicide as disobeying Buddhist teachings by lacking kindness even to himself. However, neither Buddhism or Hinduism condemns a person for the offense, prefering instead to lament suicide as a serious error or mistake. However, suicide or attempted suicide in the Muslim religion is a serious sin and therefore punishable as a crime. Self-sacrifice at the cost of one's life, however, may not be regarded the same as a suicide and may be considered an honorable act.

Attempted suicides may be more easily accepted as an illness and the family members may offer kindness and understanding to the individual insted of criticism. In Thailand, the person who attempted suicide would be accepted back and treated with tender loving care. The right of the family to know that an attempted suicide has taken place may take precedence over the individual's right to privacy since attempted suicide may be interpreted as a call for help from very family-centered individuls from Asia or the Pacific.

Identifying the Suicidal Student

Suicidal students may appear to be haggard and glassy eyed due to loss of sleep of loss of appetite. They may have thought about suicide for some time as a way of escaping their unhappy life or releasing their family from their burden. East Asian students generally try to keep an external calm in keeping with their value of self control even in the midst of great troubles. It is important for the FSA to try to establish a feeling of concern for the individual in crisis. An immediate referral in these times may seem like a rejection rather than a helpful gesture. While it may be critical to refer the student to a physician, psychiatrist, or psychologist, it is also important for the FSA to be willing to listen first to establish the relationship and confidence before the students expose their feelings with a professional counselor or psychiatrist.

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Notes to the FSA on Suicide and Attempted Suicide

Few Asian students would openly admit they are having suicidal thoughts. If the FSA suspects that a student may be suicidal by what is said or by the student's appearance, asking direct questions may help to assess the depth of the problem and open communication about the student's feelings. These questions may be:

1. Have you been sleeping regularly? When did you last have a good meal? These questions would give a clue to the state of tension in the student.

2. Have you been thinking of suicide? If so, by what means? And do you have the means available?

3. How long have you been thinking of committing suicide? When do you plan to kill yourself? Some students may have been collecting pills all along. These questions tell the FSA if there is immediate physical danger.

4. Ask the student if he has been seeing anyone about the problem. If the student is seeing a counselor or psychiatrist, it may be important to consult with the counselor and perhaps arrange for the student to return to the counselor (or find another one). Students may be unwilling to talk to anyone else, but may be willing to see a doctor who can help them with their sleep or eating problems. If the student is unwilling to talk to someone for professional help, then it is important for the FSA to seek advice on the best way to proceed. If the student is in physical danger to himself or others, a psychiatrist will need to be consulted for possible hospitalization. The FSA should accompany the student to see the doctor to provide some continuity for the student and the doctor. It may be necessary for the FSA to be the direct link between the doctor and the family in cases of severe mental breakdowns.

DEATH AND RELATED ISSUES

Death of the Student

While all deaths are unpleasant, the problem of an untimely death is even more so. In the death of an American student, the families can be called and they will be expected to take care of the many details associated with a death. Unfortunately, when a foreign student dies far away from his family and familiar resources, the FSA may be directly responsible for contacting the family and making the final arrangements. In the case of an accidental death, accuracy of reporting is critical and correct information must be given to the authorities and the family so there is a minimum of confusion. An excellent checklist adapted from the East-West Center, Honolulu, Hawaii, gives step by step guidelines to follow in case of an untimely death.

Religious beliefs are important to consider at this time and school records indicating denominational preferences will help to determine who to call for religious rites and assistance. In the death of a Muslim student (students from Indonesia, Pakistan, and Malaysia are often Muslims), the mosque should be called immediately because Muslims have strict beliefs requiring preparation of the body and burial immediately following a death. Friends of the student, especially those from the student's home country, are excellent sources of information and help during this period, and should be called upon to assist with informing the family, and with religious and cultural rites in times of death.

The Consulate representing the country from which the student comes can give valuable advice about the necessary preparations to be made and even may assume responsibility for the details. Most consulates are familiar with regulations regarding the sending of bodies, cremation, or required procedures. This alleviates many of the concerns of the FSA. Lists of consular representatives in the U.S. are available by calling the Federal Information number. In Hawaii it is 546-8620. Consulates are prepared to help in notifying family and assisting in their travel to the U.S. if this is desirable.

Death in the Family

Fortunately, not many deaths occur among the students during their stay in the United States. However, a crisis can occur when a student is notified about the serious illness or death of his parents or loved ones. If the illness or death is in the home country a student may be summoned to return home. It is important for the FSA to help the student with the decision to return or not return home at this time. The

oldest son of most Asian and Pacific Islanders has responsibilities to the family. In the case of a Hindu family the oldest son may be needed to perform religious rites and observe mourning rituals as required by their religion and culture. Micronesians and Samoans may also have to return home to settle property and inheritance rights. For students who must go home, the FSA can assist in making travel arrangements which may include contact with the family for funding so that the student can be home by the quickest means possible. Immigration documents to enable the student to return to school when it is possible should not be forgotten.

A student may not be able to return home because of financial constraints or on advice from the family. He may feel a sense of guilt for being so far away at this critical time, unable to participate in the last rites and contribute to the family's well being. The student should be encouraged to carry out the traditions of the family as best as he can. Chinese students may wear a black armband or wear a white or blue ribbon to signify the recent death of a family member. Hindu rites require fasting and wearing sack cloth for 13 days after death. The FSA can help in consoling the student and offering assistance when necessary.

When the student experiences the death of a parent, not only is there a sense of loss, but also there may be insecurity in the financial situation caused by this death. The FSA can help by addressing the concerns of the student and, in-temporarily if necessary. The feelings of loneliness may not be as heavy if there is sufficient support for the student from friends at this difficult time.

CHECKLIST: For Foreign Student Advisers handling death-related events for international students/scholars.

_____ 1. If the death was not in a hospital, an ambulance and the police should be called immediately.

_____ 2. Before proceeding, obtain positive identification of the body.

_____ 3. Notify appropriate school officials:

A. Notify the Dean of Students or appropriate campus official, host family, etc.

B. If the deceased was a dormitory resident, inform the appropriate housing officer. The deceased room will be secured and personal items are to be inventoried. These items will later be claimed by the next-of-kin.

_____ 4. A member of the institution should be designated as responsible for the coordination of the various tasks necessitated by the death of a student/ scholar.

_____ 5. Identify the students national leaders, religious leaders, and friends.

_____ 6. Inform the nearest Consulate.

A. Request notification of the next-of-kin and give instructions concerning the following:

1. Request instructions regarding funeral arrangements: Shipment of body home or burial here? Embalm body or not? Cremate or not?

2. Request name of person authorized to administer student's estate. If there is no next-of-kin in U.S., could be consular officer or foreign student adviser, etc.)

_____ 7. Arrange for a telegram to be sent to the next-of-kin which:

A. Informs him/her of the unfortunate event.

B. Asks for an immediate written statement (if the next-of-kin is not coming to the U.S.) authorizing the educational institution to

begin handling the pressing and necessary mortuary matters. Mortuaries need next-of-kin (or designated) authorization before picking up the body from the medical examiner's office. (It is also advisable to pick a mortuary that is familiar with international laws regarding the shipping of bodies, etc.) Note: National Group Presidents are very helpful in many matters of communication, especially international telephone calls, etc.

_____ 8. Handle the various tasks required in such an event. These might include arranging for packing and shipping of personal items, arranging for the remains to be flown to and properly received at a certain destination, the desires of the next-of-kin and helping to carry them out. If the next-of-kin arrives at your institution, this person will assume the duties. In any event, close contact should be maintained with the mortuary staff, whose profession requires knowledge of the various details involved, of how to prepare the legal documents, and of any special requirements needing attention, etc.

_____ 9. Prepare condolence letters, including a draft letter of condolence for the president of your institution.

_____10. Decide if any internal announcements (department, school paper, etc.) should be made, collect newspaper articles, photographs taken by fellow students, host family, etc., to give to the family of the deceased. Prepare media release of death as necessary.

_____11. Notify other agencies, such as landlord, phone company, other utilities, bank, etc.

Questions to consider:

1. Any strong culturally religious sensitivities to embalming a body. Cremation? Autopsy? (Most of these questions will be decided by laws of the particular state in which the death occurred.)

2. State laws. (Transportation of bodies, public funerals, foreign permit for removal, burial of other disposition, death certificate, inquests, coroners, etc.

3. Financial questions - Responsibility and obligations of the Foreign Student Adviser as the official representative of the institution.

4. Which mortuary should be asked to handle the arrangements.

5. Will the next-of-kin pay for the minimum costs for the coffin and other related items/services, or something more.

Adapted from East-West Center policy, 1986.

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EVALUATION

Perhaps you may have experiences or observations that may be valuable in making this handbook more complete. Please feel free to express your comments on this handbook. Please comment on or make additions to the following sections:

Asian and Pacific Health Systems

American Health System

Prevention

Crisis

Did you find this book helpful?

Are there any points with which you would disagree or question? Please explain.

We appreciate the time you have taken to answer this evaluation. Please send this completed sheet to:

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